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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ Comments on URAC Patient Centered Health Care Home 8/2/10

Thank you for the opportunity to comment on URAC (Utilization Review Accreditation Commission) Patient Centered Health Care Home Education and Evaluation Program. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to “keep families at the center of children’s healthcare”. Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), New Jersey’s federally funded Parent Training and Information Center, and Family-to-Family Health Information Center. SPAN also houses the Integrated Systems grant in collaboration with PCORE (Pediatric Council on Research and Education – nonprofit arm of the American Academy of Pediatrics) on the medical home project and recently received the national Art of Novel Partnership Award in Washington DC. The Family Voices Coordinator also serves as the NJ Caregiver Community Action Network representative for National Family Caregivers Association, representing caregivers across the lifespan, in a volunteer capacity. Our comments are based on our work with thousands of New Jersey families of children with special healthcare needs as well as the experiences of our own staff, most of whom are parents of special children.

Comment Area #1 Definition of a Patient Centered Health Care Home

We strongly support the definition that “puts patients, their families, and caregivers at the center of all decisions concerning the patient’s health and wellness”. We support “health management tools” for prevention. Family Voices-NJ has been an ongoing partner in the Bright Futures guidelines; we were the only state to hold focus and support groups in Spanish and the first nationally to hold focus groups for parent input on the current revisions. We believe that a health home “empowers patients to be active participants in their care” including consideration of “health literacy, values, beliefs, and cultural background.” NJ just held its first statewide summit on health literacy and used the models developed in Missouri (see www.mffh.org/pag2.html) and Wisconsin (see www.wisconsinliteracy.org). We attended the statewide summit on health literacy which found this is the largest barrier to healthcare access. A significant barrier is lack of cultural and linguistic competency; lack of language access is one of the most challenging barriers to overcome. Health literacy is the largest barrier for all groups, including underserved populations. Latest estimates indicate that 1 in 7 adults, or 32 million Americans, can’t read the instructions on a medication bottle. The costs of healthcare literacy are high, besides the human factor of poor health outcomes. The University of Connecticut study showed that \$106-238 billion is lost every year on

healthcare costs due to poor communication between patients and providers. The New Jersey Department of Education recently revised the Core Curriculum Content Standards for all students statewide to include health literacy, which is a model for other states. The American Medical Association has also developed a free video addressing the issue of health literacy at www.ama-assn.org/ama/no-index/about-ama/8035.shtml . We also support that the health home is “accountable for the patient’s needs, including prevention, wellness, medical and behavioral health...” Again, wellness is important because particularly for children with special needs so often the focus is on the condition and basics like immunizations are missed. Further, as SPAN staff serve as a volunteers and local board members of the National Alliance on Mental Illness, Family Support Organizations, and a chapter of the Federation of Families for Children’s Mental Health, we are pleased to see behavioral, not just physical health, addressed.

Comment Area #2 Guiding Principles of a Patient Centered Health Care Home

Principle 1 Patient Centered Care Culture

We strongly support patient, or family-centered care, as appropriate.

Principle 2 Appropriate Access to Care

We agree that families must have access to care. We would expand this to include community based care, after hours care for urgent needs, comprehensive care, as well as physical accessibility for people with disabilities.

Principle 3 Individualized Care Planning

We strongly support individualized care plans. We would suggest that for children, practitioners can use forms like the Universal Child Health Record (form CH-14) and the Care Plan for Children with Special Health Needs (form CH-15) both available at <http://web.doh.state.nj.us/forms> as templates to develop plans for individual children.

Principle 4 Effective and Timely Care Coordination and Follow-Up

We strongly agree care coordination is in keeping with the concept of the “health home”. We would add “continuity of care” for better health outcomes. We are concerned that “managed care” was originally developed for a “well” population and as currently practiced may not be appropriate for children and adults with significant and/or complex health needs.

Principle 5 Eliminating Health Care Disparities

We strongly support initiatives that seek to eliminate health disparities. The NJ Hospital Association found that the uninsured were Hispanic followed by African American families. Children and adults who are uninsured are diagnosed on average 2 years after their covered counterparts. The National Early Childhood Technical Assistance Center found that the underserved were children from Hispanic followed by Asian families. The NJ Title V Block grant showed that infant mortality rate for African American families was three times higher. Addressing health disparities is not only cost effective when disease is easier to treat, but more importantly results in decreasing morbidity and mortality due to better health outcomes. In seeking to eliminate health disparities, care must be culturally competent, which needs to be added in this section.

New Jersey was the first state to pass a statewide mandate for cultural competency training for healthcare providers (see www.state.nj.us/lps/ca/bme/press/cultural.htm), which should be mandated nationally. Some religious beliefs, for example, don't allow for blood to be drawn for a lead screening. Some cultures have shame and blame regarding mental health issues. Others have stigma associated with disability. Still others are fearful of any system, including healthcare, due to recent immigration raids. Besides onsite translators, AT&T language lines and IBM computer translation programs can assist in communicating with patients in other languages by phone and email. We do agree that use of Health Information Technology, including telemedicine, will increase health care access and care coordination, *but only if* implemented with the active, informed, meaningful, and "listened to" input of families/patients/consumers.

Principle 6 Promoting Care Quality and Continuous Quality Improvement

We agree that access to care is meaningful and effective only if it is quality care and note that there remain great disparities in access to quality care based on income, race, language, immigrant status, socio-economic status, and geography, among others.

Principle 7 Stewarding the Cost-Effective Use of Health Care Resources

We support cost effectiveness but only if it does not affect healthcare access and quality. We agree with the shared responsibility of families and providers which results in better health outcomes and cost savings. A good example of this is Health Dialog at www.healthdialog.com/Main/PersonalHealthCoaching/SharedDecisionMaking . In NJ we use the Take Control of Your Health program found at www.state.nj.us/health/senior/healthease.shtml#control which is based on the national Stanford program. For those with chronic diseases (68% of those over age 44), Stanford has a proven effective patient education program which should be funded nationally. According to the National Council on Aging survey of this age group, 57% say their doctor doesn't ask if they can manage their condition at home. Post-outcomes include reduced doctor visits, emergency room use, and hospitalization. Estimated cost savings per patient range from \$390-\$750 per participant. For more information, see <http://patienteducation.stanford.edu/programs/cdsmp.html>.

Principle 8 Excellence in Customer Service

We strongly support "surveying patients" and "using this information to continuously improve...". Results of patient surveys should be made widely available so that patient, practice, and government all have needed information available to support quality improvement.

Principle 9 Commitment to Transparency

We strongly agree with use of "validated data on...clinical outcomes". We also somewhat agree with reducing "unnecessary utilization and costs" but mostly in terms of overuse of hospital emergency rooms. We have found that budget cuts in Medicaid for example resulted in decreased utilization but increased costs because families weren't buying prescriptions they couldn't afford, or weren't getting mental health help, and both resulted in increased hospitalizations.

Principle 10 PCHCH Infrastructure and Operations

We agree with “organizational and operational infrastructure...team structure, clearly delineated...staff responsibilities, and ...training”.

Comment Area #3 Health Care Practice Assessment Toolkit

In general, there are 13 areas of assessment and each is broken down into multiple “characteristics”. We feel that this will be too overwhelming for practitioners. In this day of managed care and 15 minute visits, the assessment process needs to be user friendly and efficient. Many of the characteristics are overlapping and duplicative.

1) Partnership Agreement (PA)

Characteristic PA-1: Partnership Agreement

We agree that the practice should have PCHCH related materials but not necessarily that they have to develop their own, but can use existing materials. We also agree that staff must be trained in this area.

Characteristic PA-2: Partnership Outreach

We agree that informing patients, using a systematic approach, is necessary.

Characteristic PA-3: Partnership Engagement

We support that there needs to be an explanation of patient and team roles and it includes “patients/families/caregivers” as needed.

Characteristic PA4: Partnership Implementation

We agree with different categories of percentages of current patients but feel that perhaps it could be low (25% or less), middle (50%-74%), high (75 %+) rather than 10%, 30%, 50%, 60%, 80%, and 90% listed.

2) Patient Registry (PR)

In general, we agree that the registry (except PR-2), could be paper or electronic as practices transition to “health care home” models.

Characteristic PR-1: Registry Implementation

We support tracking “high prevalence and/or high risk conditions”.

Characteristic PR-2: Registry is Electronic

Although allowance is made for paper registries, we believe electronic registries will be more efficient and cost-saving.

Characteristic PR-3: Registry Clinician Attribution

We agree that a record must be kept for every patient in the practice who has a medical home.

Characteristic PR-4: Registry Demographics and Clinical Parameters

We strongly agree that demographics must be tracked to allow that “needs and treatment are provided equitably”.

Characteristic PR-5: Registry Clinical Information

We support documentation of a “substantial majority of health care services received at other sites...to manage chronic conditions”.

Characteristic PR-6: Electronic Information Systems Used for Managing Patient Care

This can be mentioned in PR-4 and PR-5 above regarding demographic and clinical data in the registry rather than a separate “characteristic.”

Characteristic PR-7: Registry Incorporates Guidelines and Team Approach

We strongly support tracking of evidence based guidelines.

Characteristic PR-8: Registry at Point of Care

We strongly support access to the registry at the point of care, whether it's the office, hospital, etc.

Characteristic PR-9: Registry Used for Prevention

We strongly agree with tracking prevention and wellness.

Characteristic PR-10: Registry Flags Gaps in Care

We support tracking gaps in care, whether it's related to illness or prevention.

Characteristic PR-11: Registry Generated Communications

We agree that gaps should be communicated to patients but would fold this into PR-10 above.

Characteristic PR-12: Registry of Non-Practice Patients

We agree that tracking must also happen for patients assigned by managed care plans.

3) Access to Services (ATS)

Characteristic ATS-1: Patient Telephonic Access to Care

We agree with 24 hour access however feel that a 24 hour feedback loop is too long in cases of urgent care.

Characteristic ATS-2: Patient Information Available to Clinician

We agree that the registry must also be available to the 24 hour provider but would add this to PR-8 regarding point of care.

Characteristic ATS-3: Patient Access to After-Hours Care

We support after hours care at least 8 hours a week but again disagree if it is a different site a 24 hour feedback loop is sufficient for urgent needs.

Characteristic ATS-4: Patient Information on After-Hours Care

Although we agree on informing patients of after hours, we would fold this into ATS-3 above.

Characteristic ATS-5: After-Hours Clinician Access to Patient Information

We agree the after hours provider should be able to prescribe, access, and update the registry but would fold this into PR-8 above.

Characteristic ATS-6: Advanced Access Scheduling

We agree with leaving time open for same day appointments.

Characteristic ATS-7: Enhancing Patient Access to Care

We agree that phone or email communications must be incorporated into the registry but would include this in PR-8. We support the notion that patients should get health records on request and summaries after visits. We agree with monitoring if the patient is seeing their physician of choice. We also agree there should be standing orders on routine medications but would put this in ICM-12. We support training in communicating with vulnerable populations but would add this to ATS-10.

Characteristic ATS-8: Ensure Equitable Access and Services

We support policies on forbidding discrimination.

Characteristic ATS-9: Ensure Appropriate Use of Clinical Guidelines

We support tracking services regarding clinical guidelines but would fold this into PR-7 regarding evidence based treatment.

Characteristic ATS-10: Language Translators

We support telephonic or other access to languages common to the patients in the practice.

4) Individual Care Management (ICM)

Characteristic ICM-1: Staff Training in Care Management

We agree with staff training on this but would add it to PA-1 on PCHCH above.

Characteristic ICM-2: Care Management - Integrated Team

We agree in a multidisciplinary team approach.

Characteristic ICM-3: Care Management - Use of Guidelines

We strongly support evidence-based guidelines but would fold this into PR-7.

Characteristic ICM-4: Ongoing Care Management Protocols – All Patients

We agree with chart review prior to the visit. We agree with the care plan and visit summary but would fold that into ATS-7. We also agree with supporting “adopting healthy behaviors” but would fold that into PS-6 on promoting well care.

Characteristic ICM-5: Chronic Condition – Care Management

Although we agree with “at least one chronic condition...identified for initial focus”, a comprehensive approach must be utilized, including addressing comorbidities, for an ongoing effective “health home”.

Characteristic ICM-6: Chronic Condition – Action Plans

We support self-management to the extent possible but add SMS-2 on self management support to this.

Characteristic ICM-7: Chronic Condition – Appointments

We agree with appointment tracking and reminders.

Characteristic ICM-8: Chronic Condition – Follow-Up

We agree with follow-up on treatments for chronic conditions but would fold this into ICM-15.

Characteristic ICM-9: Chronic Condition – Planned Visits

We agree with regular appointments for initial focus but would fold this into ICM-7 regarding appointments.

Characteristic ICM-10: Chronic Condition – Group Visits

We disagree with group visits, other than support groups. Patients, even with the same diagnosis, need individualized care. Further, with group visits patient privacy is at risk. Certain patients may have cultural or language barriers that would keep them from honestly expressing concerns with group visits, or with relating health concerns during group visits.

Characteristic ICM-11: Medication Review

We agree with medication review but would fold this into ICM-12. We disagree that the provider should “recommend...generic substitutions” as in some cases such as anti-seizure or anti-psychotic medications, generics are not as effective.

Characteristic ICM-12: Electronic Prescribing Utilized

We strongly support electronic prescriptions which would also avoid errors in legibility and drug interactions and allergic reactions, but again disagree with preference to generics.

Characteristic ICM-13: Self-Management

We agree with a self-management plan and would add SMS-2 to this.

Characteristic ICM-14: Appointments

We agree with appointment tracking and reminders but would fold this into ICM-7.

Characteristic ICM-15: Follow-Up

We agree with follow-up for patients both with and without chronic conditions.

Characteristic ICM-16: Planned Visits

We support planned visits for chronic conditions after the initial focus, but would fold this into ICM-7.

Characteristic ICM-17: Group Visits

We do not support group visits, even after the initial focus, and would fold this into ICM-10.

5) Test and Imaging Results (TIR)

Characteristic TIR-1: Documented Test Tracking Procedures

We agree there should be tracking of all tests and follow-up (both positive and negative results).

Characteristic TIR-2: Systematic Testing

We agree with tracking patient's receiving needed tests but would fold this into TIR-1.

Characteristic TIR-3: Staff Training on Test Tracking

We agree that staff must be trained in tracking tests but would fold this into PR-3.

Characteristic TIR-4: Patient Contact Information Updated

We agree with updating patient contact information but would fold this into PR-3.

Characteristic TIR-5: Lab and Imaging Tracking and Follow-Up

Again we agree with tracking tests, including labs and follow-up, and recording in the record but would fold this into TIR-1.

6) Preventive Services (PS)

Characteristic PS-1: Primary Prevention Program

We strongly support proactive measures for risk reduction.

Characteristic PS-2: Preventive Services Approach

We agree prevention measures should be systematic but would fold this into PS-1.

Characteristic PS-3: Preventive Services Program

We agree with documentation and use of assessment tools.

Characteristic PS-4: Prevention Services Protocols

We do not agree with delivery of all preventive services, even if physician approved, without a clinician examination.

Characteristic PS-5: Secondary Prevention Program

We support treating both symptomatic and asymptomatic patients who are at risk but would fold this into PS-1.

Characteristic PS-6: Promote Well Care

We agree with well visits in addition to "sick" visits.

Characteristic PS-7 Comprehensive Health Risk Assessment

We agree with establishing a baseline but would fold this into PS-3 regarding assessment.

Characteristic PS-8: Care Coordination Through Collection of Health Encounter Patient Data

We strongly agree with documentation of "outside health encounters" but would put this under PR-5 regarding other health providers.

Characteristic PS-9: Staff Training in Health Promotion

We agree that staff training is needed in this area.

7) Community Services & Resources (CSR)

Characteristic CSR-1: Comprehensive Review of Community Resources

We agree that community resources are important in health promotion. Indeed it is one of the key components of our state medical home pilot project. This is especially important for families and patients with special healthcare needs.

Characteristic CSR-2: Community Resource Database

We also agree with a resource database but would just add this to CSR-1.

Characteristic CSR-3: Collaboration with Community Resources

We strongly support collaborative relationships for better health outcomes. Our medical home project as an example, is a collaboration between PCORE and our Parent Training and Information Center, referring to other community resources, to establish a medical home for children with special needs.

Characteristic CSR-4: Staff Training on Shared-Decision Making and Referring Patients to Community Resources

We agree that training is needed on shared-decision making. We also agree training is needed on community resources but would put that under CSR-1.

Characteristic CSR-5: Community Resource Referral System

We agree with a referral system for resources, but would put this under CSR-1.

Characteristic CSR-6: Tracking Community Resource Referrals

We also agree with tracking referrals to resources, particularly like systems of care for early intervention, mental health, etc. but would fold this under CSR-1.

Characteristic CSR-7: Follow-Up of Community Resource Referrals

We also agree with follow-up but again this could be covered under CSR-1.

8) Self-Management Support (SMS)

Please note that we feel that the entire section 8 can be blended into section 4 above (Individual Care Management) as self management is part of this.

Characteristic SMS-1: Staff Training on Self-Management Support

Training staff on self-management can be handled under ICM-1.

Characteristic SMS-2: Chronic Condition – Self Management Support

Self management support for chronic conditions falls under ICM-5.

Characteristic SMS-3: Chronic Condition – Self Management Support Follow-Up

Self management follow-up would fall under ICM-8 which can be combined with ICM-15.

Characteristic SMS-4: Assessment of Patient Self-Care Capabilities

We agree with the assessment of self-management but would add this to ICM-13 as part of the action plan.

Characteristic SMS-5: Patient and Care Team Surveys of Self-Management Support

We agree with evaluation of self-management but would add this to ICM-4 on ongoing self-management.

Characteristic SMS-6: Self-Management Support Implementation

We believe self-management should be for all patients so this goes with SMS-2 which can then be added to ICM-5.

Characteristic SMS-7: Self-Management Support Follow-Up

We think there should be follow-up for all patients so this goes with SMS-3 which can then be added to ICM-15.

Characteristic SMS-8: Self-Management Support for All Patients

There is no need to say it's for all patients if SMS-2 and SMS-6 are combined, and if SMS-3 and SMS-7 are combined, all of which fall under ICM-5 and ICM-15 respectively.

9) Patient Web Portal (PWP)

We feel that most of section 9 can be folded into section 2 (Patient Registry) perhaps as the broader category of Health Information Technology, using the final revisions to the HIT meaningful use definition.

Characteristic PWP-1: Evaluation of Patient Web Portal Systems

We strongly support evaluation of safety of information particularly as it relates to HIPAA, mental health/substance abuse, and minor consent to treatment.

Characteristic PWP-2: Patient Web Portal Risk Assessment

We agree with evaluation of the web portal.

Characteristic PWP-3 Scheduling Using Patient Web Portal

We agree with scheduling using the portal but this can be blended with ICM-7 under appointments.

Characteristic PWP-4: Patient Web Portal Logs of Patient Information

We agree patients should be able to log self-administered tests but would add this to TIR-4 on lab follow-up.

Characteristic PWP-5: Clinician Alerts to Potential Health Issues

Clinician alerts could also be added to TIR-4 on lab follow-up.

Characteristic PWP-6: Implementation of Electronic Visits

We strongly support the use of e-visits and would add telemedicine to this, particularly in rural areas.

Characteristic PWP-7: Patient Use of Interactive Web Portal

We agree that clinicians can send information through the portal but would combine this with ICM-7 under reminders.

Characteristic PWP-8: Patient Web Portal –Personal Health Record (PHR)

We support the patient being able to create a PHR but would add this to ATS-7 under health records.

Characteristic PWP-9: Patient Review of Test Results

We agree that patients should be able to use the portal for test results but would add this to TIR-1 on test results.

Characteristic PWP-10: Prescription Renewals

We agree patients should be able to use the portal for renewals but would add this to ICM-12 under prescriptions.

Characteristic PWP-11: Patient Self-Management Support

We agree with using the portal for self management but would put this under ICM-13 for self management plan.

Characteristic PWP-12: Patient Review of PHI

We agree that patients should be able to use the portal for PHI but would add this to ATS-7 under health records.

Characteristic PWP-13: Availability of Patient Decision Support Tools

We agree with using the portal for decision support but would add this to ICM-13 for the self-management plan.

10) *Coordination of Care (COC)*

We strongly support Coordination of Care but feel this section can be blended with section ICM on care management.

Characteristic COC-1: Chronic Condition – Coordination of Care

We agree with tracking hospitalizations etc. but would add this to PR-5 for other health providers.

Characteristic COC-2: Medical Record Information Exchange

We also agree with information exchange but would add this as well to PR-5 for other health providers.

Characteristic COC-3: Tracking Coordination of Care

We agree with tracking care coordination, particularly for those with chronic conditions or at high risk but would add this to PR-1 on tracking.

Characteristic COC-4: Chronic Condition – Health Issue Alerts

We agree with alerts for time sensitive matters but would add this to PR-10 under gaps in care.

Characteristic COC-5: Written Transition Plans

We support written plans for transition but would add this to PR-5 for other health providers.

Characteristic COC-6: Coordination of Care with Payer Case Manager

We disagree with coordination of care though the employer for patients with complex or catastrophic conditions. We have heard of cases where employers either dropped coverage or fired “high cost” employees, or didn’t hire initially because of the health status of the potential employee or one of their dependents. We agree that there should be care coordination for complex illness but also disagree it should be through the payer as they also have a vested interest in denying care. A “center of excellence”, “united resource network”, or Title V case managers for children would be more neutral.

Characteristic COC-7: Coordinating Care Site Transitions

We agree with documenting transitions, particularly for unplanned hospitalizations, but would put this under PR-5 for other health providers.

Characteristic COC-8: Program Documentation and Training

We agree with policies on care coordination but would put this under ICM-1 staff training on care management.

Characteristic COC-9: Coordination of Care Program for All Chronic Conditions

We agree with care coordination for those with chronic conditions but feel this is covered under ICM-5 care management of chronic conditions.

Characteristic COC-10: Coordination of Care Program for All

We support care coordination for all patients, not just those with chronic conditions, but feel this is covered under ICM-4 care management for all patients.

11) *Specialist Referral Process (SRP)*

Specialist referrals fall under the area of care management.

Characteristic SRP-1: Specialist Referrals for High Volume Specialists

Referrals to high volume specialists could fall under ICM-8 care management follow-up for chronic conditions.

Characteristic SRP-2: Specialist Referrals for Other Key Specialists

Other specialist referrals could also be added to ICM-8 under care management follow-up.

Characteristic SRP-3: Specialist Referral Directory

We agree there should be a database on specialists but would also add which type of insurance they accept.

Characteristic SRP-4: Patient Information on Specialist Referrals

We agree patients should have access to specialist information but would blend this with SRP-3.

Characteristic SRP-5: Staff makes Specialist Appointments

It may be helpful for staff to facilitate appointments, particularly for subspecialties which may have 6-9 month wait lists or in cases of complex care where multiple appointments are needed at the same facility. However, this should be done in collaboration with the family schedule to minimize interference with work schedules or multiple trips to the same facility.

Characteristic SRP-6: Electronic-Based Tools for PCP and Specialist

We strongly support avoiding duplication of tests but this would fall under TIR-1 for tracking tests.

Characteristic SRP-7: Track and Follow-up on Specialist Referral

We agree with report backs from specialists but this could be combined with PR-5 other providers.

Characteristic SRP-8: Staff Training on Specialist Referral Process

We agree that training is needed in this area but this could be combined with CSR-1 training on community resources.

Characteristic SRP-9: Patient and Care Team Member Surveys on Specialist Care

We agree with evaluation of specialists but would add this to PR-5 other providers.

12) Performance Reporting (PRT)

We would strongly recommend using the Family Centered Care Provider Tool at www.familyvoices.org/pub/projects/fcca_ProviderTool.pdf and family tool at www.familyvoices.org/pub/projects/fcca_FamilyTool.pdf as templates. We would also recommend the medical home measurement tools for adult www.medicalhomeimprovement.org/pdf/CMHI-MHI-Adult-Primary-Care_Short-Version.pdf and pediatric populations www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Short-Version.pdf from the Center on Medical Home Improvement.

We also feel that the Performance Reporting and Organizational Structure could be added to section PA on Partnership Agreement perhaps under a general Practice Area section.

Characteristic PRT-1: Performance Reporting – High Prevalence/High Risk Condition Patient Population

We agree with evaluation of high risk conditions but would add this under PR-1 tracking chronic conditions.

Characteristic PRT-2: Performance Reporting of Practice Levels

We agree but feel the report should be at the individual clinician level, rather than the entire practice, and that this should be available to the public.

Characteristic PRT-3: Performance Reporting Validation

We agree that data reported must have reliability and validity.

Characteristic PRT-4: Performance Reporting – Trends Analysis and Action

We agree with data analysis of reduced hospitalization etc. but caution that this must be balanced with evidence based practices and not misused to decrease healthcare utilization and deny access to care.

Characteristic PRT-5: Performance Reporting for All Ages

We agree that all ages should be reported but would suggest grouping by age as the same conditions may manifest differently in children than adults.

Characteristic PRT-6: Performance Reporting – Prevention

We agree with tracking prevention and outcomes but would add this under PR-9 tracking wellness.

Characteristic PRT-7: Performance Reporting – Population Based

We support this data tracking but would add this to ATS-10 for vulnerable populations.

Characteristic PRT-8: Performance Reporting – Specialist Services

We agree with evaluation of specialists but would add this to SRP-9 evaluation of specialists.

Characteristic PRT-9: Performance Reporting – Other Services

We support evaluation of other care besides specialists, such as hospitals, but would also add this to SRP-9.

Characteristic PRT-10: Continuous Quality/Consumer Satisfaction Improvement

Activities – Trend Analysis and Action

We strongly support patient satisfaction surveys.

Characteristic PRT-11: Performance Reporting Transparency

We agree with reporting transparency but feel this could be combined with PRT-2 on performance reporting.

13) PCHCH Organizational Core (CORE)

Characteristic COR-1: Organizational Structure

We feel that teamwork, tracking, and quality improvement falls under PRT-2 on performance reporting.

Characteristic COR-2: Organization Documents

We agree with listing the mission and population served but would add availability of other languages, including sign language, as well as type of insurance accepted.

Characteristic COR-3: Regulatory Compliance

We support compliance with current regulations but feel this could be added to PRT-2 under performance reporting.

Characteristic COR-4: Information Management

We agree that information systems must be efficient and timely both inside and outside the practice but would add this under Health Information Technology with the combined sections of PR and PWP (patient registry/patient web portal).

Characteristic COR-5: Information Confidentiality and Security

We agree that information systems must be secure but this can be combined with PWP-1 safety of web portal.

Characteristic COR-6: Confidentiality of Individually Identifiable Health Information

We also agree with confidentiality of PHI but again this can fall under PWP-1.

Characteristic COR-7: Staff Qualifications – Job Descriptions

We agree that staff roles must be defined but this falls under PA-3 team roles.

Characteristic COR-8: Staff Training Requirements

We agree with training in all these areas but feel that shared decision making is covered under CSR-4, staff roles under PA-3, cultural competence under ATS-10, care coordination under ICM-1, referrals under SPR-8, etc.

Characteristic COR-9: Staff Teamwork Optimization and Job Satisfaction

Teamwork etc. would fall under PRT-2 performance evaluation.

Characteristic COR-10: Patient Empowerment and Engagement

Satisfaction with self management falls under SMS-5 and cultural competency under ATS-10.

Characteristic COR-11: Patient Satisfaction

Again patient satisfaction is covered under PRT-10 trend analysis.

Characteristic COR-12: Patient Safety Mechanism

We agree that there should be an emergency plan for threats to safety of patients.

Characteristic COR-13: Optimizing Care Value – Awareness of Clinical Advances

We agree with awareness of clinical advances but this is covered under PR-7 evidence based practices.

Characteristic COR-14: Optimizing Care Value – Protocols for Consideration of Cost Effective Diagnostic/Treatment Options

We feel that this is also covered under PR-7 but disagree with discussing options with patients based on cost.

Characteristic COR-15: Provision of Cost/Benefit Information to Patients

Again, we strongly disagree with decision aids/shared decision making discussions based on treatment cost.

Characteristic COR-16: Establishing and Utilizing a Trusted Referral Network

We support a good referral network but this is covered under SRP-9 evaluation of referrals.

Comment Area #4 General Comments

We agree with most of the assessment areas and associated characteristics. Research has proven that the medical home concept is cost effective and results in better health outcomes. Patient centered care will not only focus on the individual, but increase patient compliance and responsibility for their own care. Patient/professional collaboration on healthcare increases accountability on both sides. Patient centered care will lead to decreased morbidity and mortality, cost savings, and most importantly improved health outcomes for families. Thank you for the opportunity to comment on the URAC Patient Centered Health Care Home model.

Sincerely,

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Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.