Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Homeless patients' experiences: overall mean score for the Primary Care Quality-Homeless (PCQ-H) instrument.

Source(s)

Kertesz S, Pollio D, Jones R, Steward J, Stringfellow E, Gordon A, Johnson N, Kim T, Daigle S, Austin E, Young A, Chrystal J, Davis L, Roth D, Holt C. Development of the Primary Care Quality-Homeless (PCQ-H) instrument. A practical survey of homeless patients' experiences in primary care. Med Care. 2014 Aug;52(8):734-42. PubMed

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Patient Experience

Secondary Measure Domain

Clinical Quality Measure: Access

Brief Abstract

Description

This measure is used to assess the overall mean score for the Primary Care Quality-Homeless (PCQ-H) instrument.

An overall mean score is calculated based on the patients' responses ("Strongly Disagree," "Disagree," "Agree," "Strongly Agree," and "I Don't Know") to the following items (organized by subscale):

Patient-Clinician Relationship

My primary care provider (PCP) never doubts my health needs.
My PCP takes my health concerns seriously.
My PCP makes decisions based on what will truly help me.
I feel my PCP has spent enough time trying to get to know me.
I can get in touch with my PCP when I need to.
I can get enough of my PCP's time if I need it.

If my PCP and I were to disagree about something related to my care, we could work it out.
My PCP makes sure health care decisions fit with the other challenges in my life.
I worry about whether my PCP has the right skills to take good care of me.
I can be honest with my PCP if I use drugs or alcohol.
I worry my PCP might report my health information to the authorities.
Someone from my PCP's office returns my phone calls or pages.
When I need information about my health care, like test results, I can get it easily.
The staff at this place listens to me.
Staffs at this place treat some patients worse if they think that they have addiction issues.

Cooperation among Clinicians

My primary care and other health care providers need to communicate with each other more.
I have been frustrated by lack of communication among my primary care and other health care providers.
My primary care and other health care providers are working together to come up with a plan to meet my needs.

Access/Coordination

My PCP helps to reduce the hassles when I am referred to other services.
I have to wait too long to get the health care services my PCP thinks I need.
At this place, I have sometimes not gotten care because I cannot pay.
If I could not get to this place, I think the staff would reach out to try to help me get care.
If I walk in to this place without an appointment, I have to wait too long for care.
This place is open at times of the day that are convenient for me.
This place helps me get care without missing meals or a place to sleep.
It is often difficult to get health care at this place.
This place tells me about what services are available.
The health care services I need are close to each other.
If my PCP is unavailable there is someone else that can help me.

Homeless-specific Needs

This place tries to help me with things I might need right away, like food, shelter, or clothing.
The people who work at this place seem to like working with people who have been homeless.
If I miss an appointment, this place still finds a way to help me.
At this place, I always have to choose between health care and dealing with other challenges in my life.

Response options ranged from "Strongly Agree" (value of 4) to "Strongly Disagree" (value of 1), with reverse-scoring applied to negatively worded items. Scoring for each subscale reflects computation of the mean obtained value among items available, provided at least 50% of items for each subscale have obtained a valid response.

Note: The 33-item PCQ-H instrument has 4 subscales: Patient-Clinician Relationship (15 items), Cooperation among Clinicians (3 items), Access/Coordination (11 items), and Homeless-specific Needs (4 items). There are 4 composite measures and 1 overall score measure.

Rationale

Assessing the provision of high-quality primary care for homeless persons faces challenges of operationalization and measurement. Single-disease performance metrics can be problematic in their application to special or multimorbid populations and in situations where the context of care should influence decision making (Boyd et al., 2005; Durso, 2006; Weiner, 2004). Patient-centric approaches to primary care have gained in popularity, including patient-centered medical homes (PCMHs) and the U.S. Department of Department of Veterans Affairs' (VA) Patient Aligned Care Teams (True et al., 2013). These changes in care delivery have contributed to increased interest in patient assessments of care and

team-based care (Gerteis et al., 1993), and whether care approximates priorities identified by expert consensus groups (i.e., Institute of Medicine [IOM]). Relatively little is known about homeless patients' perceptions of key aspects of care such as accessibility, continuity, coordination, principles enshrined in the Consumer Assessment of Health Plans (CAHPS) (Crofton, Lubalin, & Darby, 1999) and the Primary Care Assessment Survey (PCAS) (Safran et al., 1998).

Administration of the CAHPS with PCMH items is required of federal Health Care for the Homeless programs seeking PCMH status, and CAHPS items are now used within VA's Survey of Health Experiences of Patients (Safran et al., 1998; Hargraves, Hays, & Cleary, 2003; Campbell et al., 2003). These surveys are potentially problematic when applied to homeless patients. The CAHPS presents 43 questions (1012 words) at a ninth grade reading level (Agency for Healthcare Research and Quality [AHRQ], 2012). Twelve items are used to implement skips among the remaining 31 items, and 7 different response sets are used. For clients who are ill rested or cognitively impaired, the risk of error or overload may be high. Questions may presuppose conditions and expectations that may not apply. More pressingly, specific concerns and aspirations important to homeless patients are likely to differ from the concepts queried in standard instruments, including the pressure to balance health care against competing demands (Gelberg et al., 1997), perceptions of being unwelcome or adversely judged (Wen, Hudak, & Hwang, 2007; Ensign & Panke, 2002; Merrill et al., 2002), mutual mistrust, and other unique constraints (Shortt et al., 2008).

These concerns spurred development of a patient-reported primary care assessment instrument specifically designed to assess homeless patients' experiences in primary care, applicable in VA and non-VA settings alike.

Evidence for Rationale

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Primary Health Components

Primary care quality; homelessness; patient-clinician relationship; cooperation among clinicians; access; care coordination; homeless-specific needs

Denominator Description

Number of items responded to by homeless patients on the Primary Care Quality-Homeless (PCQ-H) instrument (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

The sum of patients' responses ("Strongly Disagree," "Disagree," "Agree," "Strongly Agree" and "I Don't Know") to items on the Primary Care Quality-Homeless (PCQ-H) instrument (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

Additional Information Supporting Need for the Measure

- On a single winter night in 2013, a total of 610,042 Americans were counted as homeless, including 57,849 United States (U.S.) military veterans (Office of Planning and Community Development, 2013), a number considerably higher when homelessness is counted over the year (Burt et al., 2001).
- The vulnerability of homeless individuals is reflected in excess mortality (Beijer, Wolf, & Fazel, 2012; Hwang, 2000; Hwang et al., 1997; Hibbs et al., 1994) hospital utilization (Buck et al., 2012; Salit et al., 1998), and poor health (Gelberg & Linn, 1989). Their access to health care is typically poor (Kushel, Vittingoff, & Haas, 2001; Baggett et al., 2010; Kertesz et al., "Unmet need," 2014), and they often feel unwelcome in care (Wen, Hudak, & Hwang, 2007).
- High-quality primary care for homeless persons could, in principle, ameliorate disparities and produce cost offsets elsewhere (e.g., fewer emergency room visits, hospitalizations), and perhaps contribute to the reduction of homelessness (Han & Wells, 2003).

Evidence for Additional Information Supporting Need for the Measure

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Extent of Measure Testing

Methods

Starting with quality-related constructs from the Institute of Medicine, the authors identified relevant themes by interviewing homeless patients and experts in their care. A multidisciplinary team drafted a preliminary set of 78 items. This was administered to homeless-experienced clients (n = 563) across 3 Veterans Affairs (VA) facilities and 1 non-VA Health Care for the Homeless Program. Using Item Response Theory, the authors examined Test Information Function (TIF) curves to eliminate less informative items and devise plausibly distinct subscales.

Results

The resulting 33-item instrument (Primary Care Quality-Homeless [PCQ-H]) has 4 subscales: Patient-Clinician Relationship (15 items), Cooperation among Clinicians (3 items), Access/Coordination (11 items), and Homeless-specific Needs (4 items). Evidence for divergent and convergent validity is provided. TIF graphs showed adequate informational value to permit inferences about groups for 3 subscales (Relationship, Cooperation, and Access/Coordination). The 3-item Cooperation subscale had lower informational value (TIF less than 5) but had good internal consistency (Crohnbach α = 0.75) and patients frequently reported problems in this aspect of care.

Calculated indices of internal consistency/reliability (Crohnbach α, McDonald ω) are as follows: Patient-Clinician Relationship (0.92, 0.96); Cooperation (0.75, 0.85); Access/Coordination (0.87, 0.94); Homeless-specific Needs (0.76, 0.88).

Refer to the original measure documentation for additional information.

Evidence for Extent of Measure Testing

Kertesz S, Pollio D, Jones R, Steward J, Stringfellow E, Gordon A, Johnson N, Kim T, Daigle S, Austin E, Young A, Chrystal J, Davis L, Roth D, Holt C. Development of the Primary Care Quality-Homeless (PCQ-H) instrument. A practical survey of homeless patients' experiences in primary care. Med Care. 2014 Aug;52(8):734-42. PubMed

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Community Health Care

Transition

Type of Care Coordination

Coordination across provider teams/sites

Coordination between providers and patient/caregiver

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Individual Clinicians or Public Health Professionals

Statement of Acceptable Minimum Sample Size

Unspecified

Target Population Age

Unspecified

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Effective Communication and Care Coordination
Health and Well-being of Communities
Person- and Family-centered Care

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Equity

Patient-centeredness

Data Collection for the Measure

Case Finding Period

Unspecified

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Clinical Condition

Encounter

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions

Number of items responded to by homeless patients on the Primary Care Quality-Homeless (PCQ-H) instrument

Note: The target population consists of persons with: (A) current or past experience of homelessness, or high vulnerability to homelessness, and (B) who have an established primary care relationship with the site providing care (this may be a designated clinic, a team of providers who work together in that clinic, or a single prescribing provider with assisting staff). Both (A) and (B) must be met.

Current or Past Experience of Homelessness or High Vulnerability to Homelessness. In considering the target population (homeless and homeless-experienced), please note that the PCQ-H instrument was developed to permit use across settings that serve populations with extreme poverty, where homeless individuals number among the service recipients, but where other respondents may not be homeless. A clinical site serving an extreme poverty population can thus utilize the survey with all respondents, rather than attempting to restrict administration of the survey to a subgroup.
Operationally, meeting any 1 of the following 4 criteria can be used to fulfill criterion A ("current or past experience of homelessness, or high vulnerability to homelessness").

The individual has an International Classification of Diseases, Ninth Revision (ICD-9) code for "homelessness" (V60.0) recorded within the prior 2 years.
The individual has a primary care relationship with an organization explicitly designated for the care of homeless individuals ("free city health care for the homeless").
The individual seeks and obtains primary care from an organization that explicitly serves an extreme poverty population, where homelessness is frequent (i.e., greater than 30%) among clientele being served. For example, such an organization may include a charity clinic that receives homeless clients and simultaneously an impoverished population of persons who are not presently homeless (e.g., "downtown medical student volunteer clinic").
The individual affirms in separate items (suggestions below) that they have a history of homelessness at present or in the past. There is no single consensus "preferred question" for confirming a history of homeless, but the authors of the instrument propose some that have been used in research.

Of the 4 criteria shown, the first 2 were explicitly used as entry criteria in the research used to develop the PCQ-H and the latter 2 reflect the designers' clinically-informed judgment of persons and settings for which the PCQ-H instrument can apply readily.

An Established Primary Care Relationship with the Site Providing Care. The authors of PCQ-H recognize that "established primary care relationships" can be attained with homeless or homeless-experienced individuals, but that the operational definition of such a relationship may not easily fit conventional methods of ascertainment used with mainstream populations. Thus, for example, patients may have Medicaid and be automatically assigned one primary care provider in a Medicaid-contracting health plan, but receive some or all actual primary care in a student-run volunteer clinic. In this instance the "relationship" is established with the student-run volunteer clinic and not the Medicaid-contracting health plan or the provider assigned at time of enrollment. For this reason the authors urge that clinical organizations using the PCQ-H consider the inclusion of additional questions (supplementary questions) to ascertain if the respondent personally perceives the clinical organization to be their site for receiving primary care. Two criteria are offered below. Of these two criteria, the first criterion was the one utilized in research used in the development of the PCQ-H. The second criterion represents the investigating team's opinion of a situation where the intended objective of an established primary care relationship is fulfilled.
Meeting EITHER of the 2 criteria below qualifies as having "an established primary care relationship with the site providing care":

The individual has obtained 2 primary care visits in the past 2 years with a provider at the site of interest (the provider is someone with prescribing authority (e.g., physician, nurse practitioner, physician assistant, or a student under supervision in one of these professions).
OR

The individual presents for care to the site of interest and provides appropriate answers to 2 supplemental questions indicating that the site is perceived as his/her regular primary care site and indicating that the visit on which the survey is received is not the first visit.

Exclusions

Unspecified

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions

The sum of patients' responses ("Strongly Disagree," "Disagree," "Agree," "Strongly Agree" and "I Don't Know") to items on the Primary Care Quality-Homeless (PCQ-H) survey

Note:

A positively worded item is scored 4 if the client "Strongly Agrees," 3 if they "Agree," 2 for "Disagree" and 1 for "Strongly Disagree." Refer to *Primary Care Quality–Homeless Survey — Scoring Version 1.0* for additional scoring information (see also the "Companion Documents" field).

Exclusions

Unspecified

Numerator Search Strategy

Fixed time period or point in time

Data Source

Patient/Individual survey

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Primary Care Quality-Homeless (PCQ-H) Survey (Version 1.0)

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Composite/Scale

Mean/Median

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Overall score.

Measure Collection Name

Primary Care Quality-Homeless (PCQ-H) Instrument

Submitter

Kertesz, Stefan, MD, U.S. Department of Veterans Affairs - None

Developer

Kertesz, Stefan, MD, U.S. Department of Veterans Affairs - None

Funding Source(s)

Department of Veterans Affairs Health Services Research and Development Branch (Grant Number: IAA-07-069-2)

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Financial Disclosures/Other Potential Conflicts of Interest

The authors declare no conflict of interest.

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2014 Aug

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

Measure Availability

Source available from the Medical Care Web site .

For more information, contact Stefan G. Kertesz, MD, MSc, at the Birmingham VA Medical Center, 700 19th St S, Birmingham, AL 35233; E-mail: skertesz@uabmc.edu.

Companion Documents

The following is available:

> Kertesz SG. Primary Care Quality–Homeless Survey — scoring version 1.0. Birmingham (AL): Birmingham VA Medical Center; 4 p.

For more information on this instrument including copies of SAS code, an Excel workbook to score all scales, a Spanish translation, and a 12-item short form (available in English, Spanish, and Chinese), contact Stefan G. Kertesz, MD, MSc, at the Birmingham VA Medical Center, 700 19th St S, Birmingham, AL 35233; E-mail: skertesz@uabmc.edu.

NQMC Status

This NQMC summary was completed by ECRI Institute on April 10, 2015. The information was not verified by the measure developer.

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Production

Source(s)

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