



National Conference
NFPRHA 2015

Patient-Centered Specialty Practice Designation

#NFPRHA1

5

NCQA's
Patient-Centered Medical Home
and
Patient-Centered Specialty Practice
Recognition Programs

What are the PCMH and PCSP Programs?

The PCMH program “is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be.”” (NCQA)

The PCSP Recognition program extends these medical home concepts to specialists.

Why pursue PCMH or PCSP?

- What are the benefits?
- What does it take to achieve it?
- Is it worth the work?

Who is eligible for the PCMH and PCSP programs?

PCMH eligibility

- Provide first contact, continuous, comprehensive, whole person care for patients across the practice – for at least 75% of patients

PCSP eligibility

- Nonprimary care specialty docs, NPs, PAs, certified nurse midwives, behavior health providers

The Vision for a PCMH

In a patient-centered medical home, patients receive the right care, in the right amount, at the right time.

Medical homes can lead to higher quality and lower costs, and can improve patient and provider experiences of care.

The Vision for a PCSP

Patient-centered specialty practices demonstrate patient-centered care and clinical quality. They use streamlined referral processes and coordinate care with referring clinicians. They have timely patient and caregiver-focused care management and conduct continuous clinical quality improvement.

What do PCMHs and PCSPs do, and how do they do it?

- They provide team-based care.
- They coordinate with other providers.
- They work to improve patient access and involvement, and meet cultural/linguistic needs.
- They utilize systematic approaches to tracking and to performance measurement.

What are the hoped for results?

- Lower costs
- Better care
- Higher satisfaction

What does it take to achieve recognition?

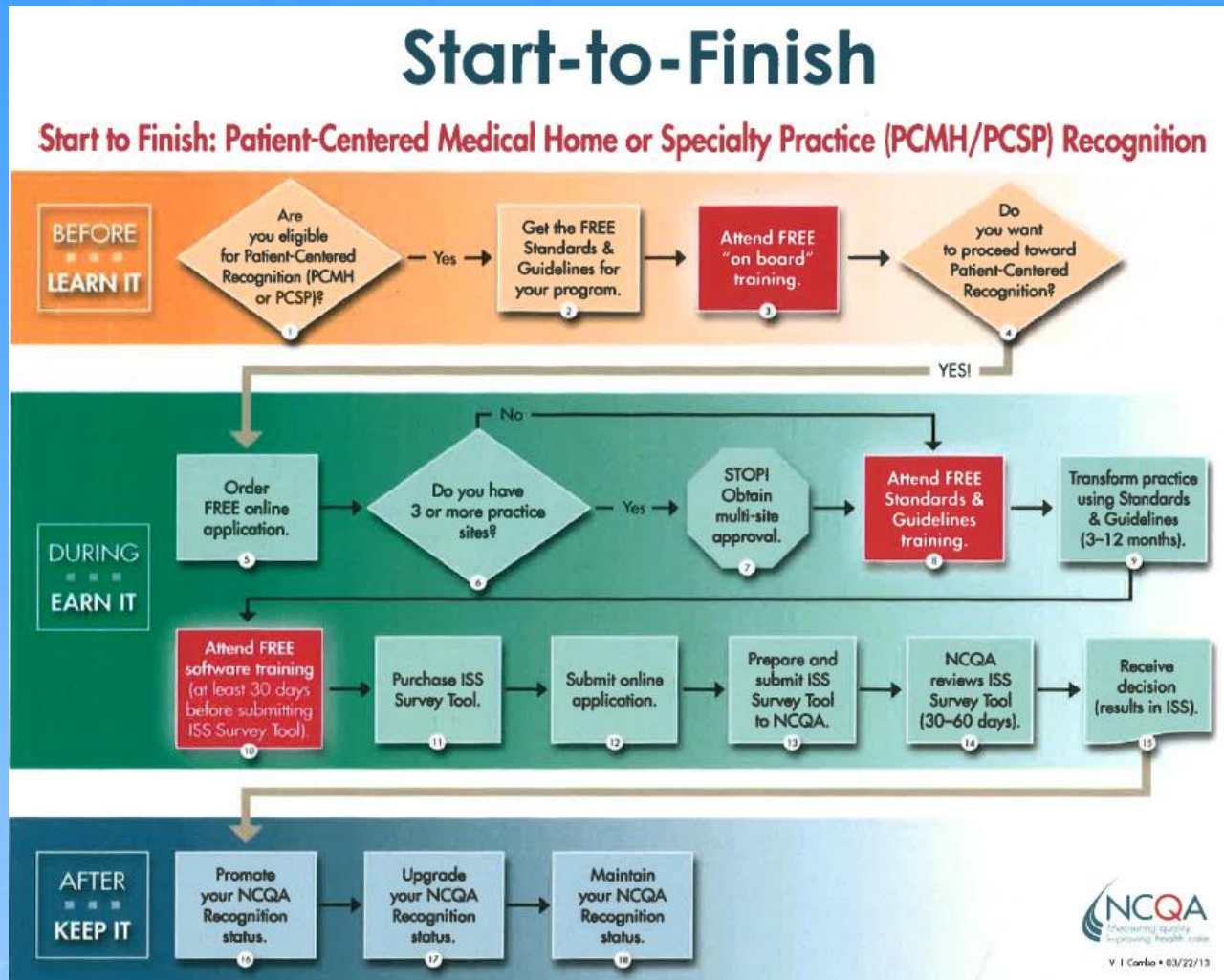
- Leadership and Practice Culture
 - Commitment to Transformation
 - Commitment to Patient-Centered Care
 - Commitment to Team-Based Care
- Formal Approach to Quality Improvement

What does it take to achieve recognition?

- Time and Resources
 - At least 6-12 months
 - Often, up to 18 months
 - Involvement from multiple staff
 - Clinical, administrative, and EHR staff
 - Executive/leadership staff
 - A dedicated project manager

Note: Some organizations report up to 800 hours of staff time to make changes, document processes, and submit paperwork.

What are the “nuts and bolts” of the NCQA PCSP Process?



April 24, 2015

Areas of Focus for PCSP (The Standards)

PCSP focuses on the following:

- handling referrals well
- making sure patients have access
- communicating well with patients
- coordinating patient populations, planning and managing care, tracking care
- measuring and improving performance

Standards

Standard

Track and Coordinate Referrals

Provide Access and Communication

Identify, Coordinate Patient Populations

Plan and Manage Care

Track and Coordinate Care

Measure and Improve Performance

Elements

PCSP 1: Track and Coordinate Referrals

22.00 points

The practice coordinates patient care with primary care practices, referring clinicians and patients to ensure a timely exchange of information.

Element A: Referral Process and Agreements

9.00 points

The practice has a written process for implementing and managing referrals with PCPs and other referring clinicians including:

Yes No

1. Formal and informal agreements with a subset of referring clinicians based on established criteria. Yes No
2. Specified methods of communication with PCPs and the referring clinician (if not the PCP). Yes No
3. Specified method of communicating with the patient/family/caregiver about specialist's plan of care. Yes No
4. Specified co-management or transition strategy for selected patients. Yes No
5. Confirmation of receipt and acceptance of referral with date and time of the appointment. Yes No
6. Specified information needed from referring clinician about patients. Yes No
7. Specified information and timing of the referral response to PCPs and referring clinicians (if not the PCP). Yes No
8. Type and method of communication with the patient and family/caregiver about results and treatment. Yes No

Scoring	100%	75%	50%	25%	0%
	The practice meets 6-8 factors	The practice meets 4-5 factors	The practice meets 2-3 factors	No scoring option	The practice meets 0-1 factors

April 24, 2015

Overall Scoring

- Level 1: 25–49 points and all 5 must-pass elements
- Level 2: 50–74 points and all 5 must-pass elements
- Level 3: 75–100 points and all 5 must-pass elements

Lessons Learned

- Important to:
 - Build buy in and understanding of the process
 - Build on (or build) a culture of transformation
 - Ensure you have clear and tangible support from leadership
 - Get everyone moving toward team-based care and working at the top of license
 - Start the processes early
 - Don't underestimate the work involved
 - Remember this is a step not a destination

What resources are available to help?

- www.ncqa.org
- Toolkit (in process)
- NCQA staff
- TA providers
- “Early Adopters”



Patient-Centered Specialty Practice Recognition

**Henrietta S. Milward, RN, BS,
PCMH CCE**

April 27, 2015

National Committee for Quality Assurance (NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

- * HEDIS – Healthcare Effectiveness Data and Information Set
- * Health Plan Accreditation * Clinician Recognition/PCMH/PCSP
- * Disease Management * ACO Accreditation
- * Wellness & Health Promotion Accreditation
- * Health Plan Rankings * Case Management Accreditation

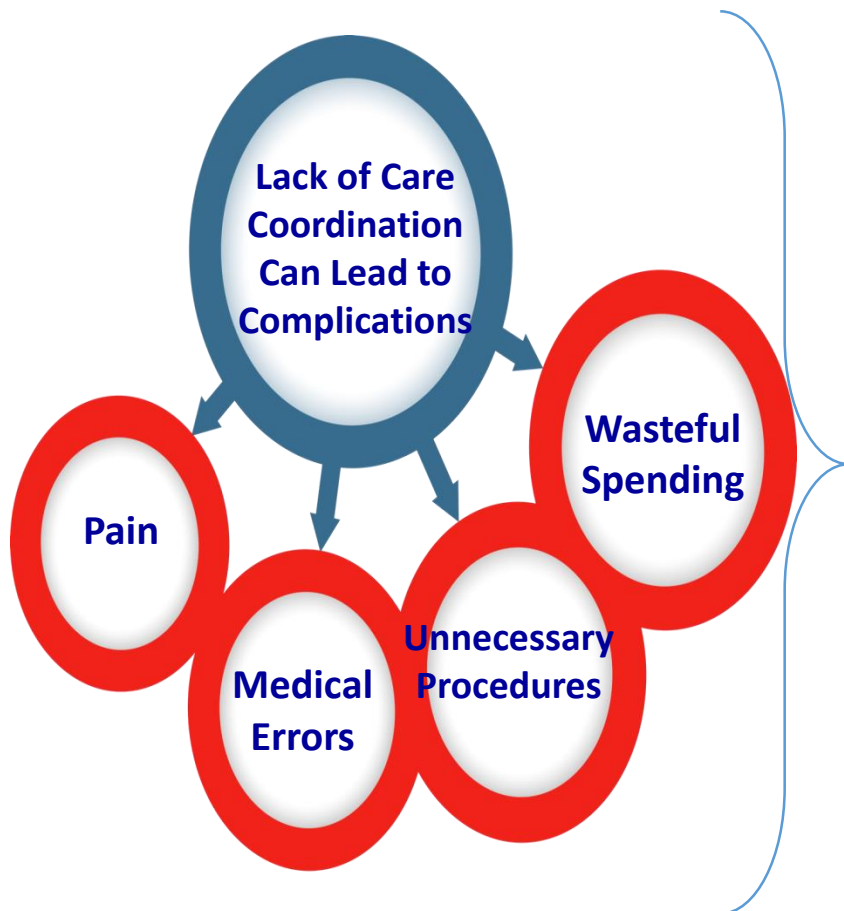
Atul Gawande on Fragmented Care.....

....”pieces of [care] don’t fit together” because we haven’t turned [care] into a system, a team of capabilities, of people with their capabilities....”



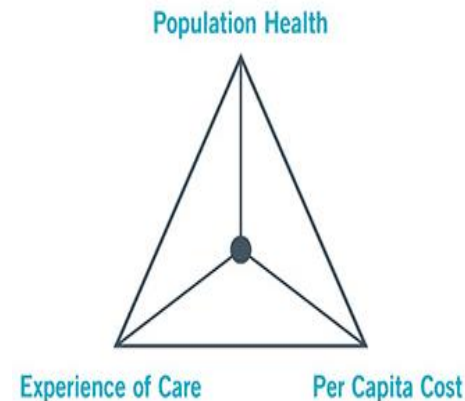
From NCQA’s December 2012 Policy Conference

Addressing the Burden of Uncoordinated Care



The Institute of Medicine has estimated that care coordination initiatives addressing these complications could result in \$240 billion in healthcare savings.²

Leading us one step closer to achieving the triple aim




The Medical Neighborhood is the answer...



- **More efficient use of services**
Lab, imaging, ER, hospitalization, return to PCP, systematic patient care management, EHR, generic medications
- **Improved patient experience**
Access, coordination, clinician collaboration, involvement in care
- **Improved outcomes**
Continuous quality improvement, use of evidence-based guidelines, medication management

Future of Reimbursement-Payments Tied to Value



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News

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

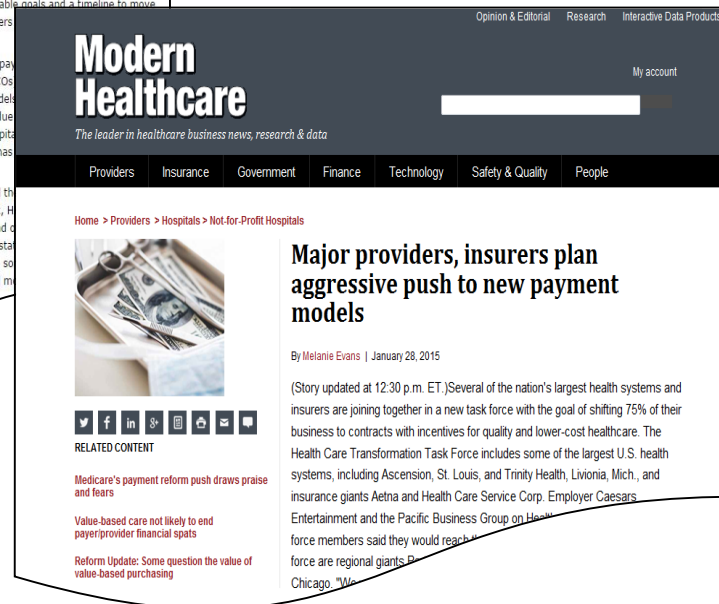
Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers more for the quality of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality through alternative payment models, such as Accountable Care Organizations (ACOs) and Shared Savings Programs, by the end of 2016, and tying 50 percent of payments to these models by the end of 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmission Reduction Programs. This is the first time in the history of the Medicare program that HHS has set a goal of tying 95 percent of all traditional Medicare payments to quality or value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of the Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with payers, employers, consumers, providers, states and state Medicaid programs, and other stakeholders to integrate alternative payment models into their programs. HHS will intensify its work with states to support adoption of alternative payment models through their own aligned work, so that the goals set for Medicare. The Network will hold its first meeting in March 2015, and will continue to meet in the near future.

"Whether you are a patient, a provider, a business, a health plan, or a state, we want to work with you to build a health care system that delivers better care, spends less money, and improves the lives of all people. Today's announcement is about improving the quality of care and the value of the health care system. It's about spending our health care dollars more wisely. It's about making sure that every dollar we spend on health care makes a difference. It's about making sure that every dollar we spend on health care makes a difference. It's about making sure that every dollar we spend on health care makes a difference."




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Major providers, insurers plan aggressive push to new payment models

By Melanie Evans | January 28, 2015

(Story updated at 12:30 p.m. ET.) Several of the nation's largest health systems and insurers are joining together in a new task force with the goal of shifting 75% of their business to contracts with incentives for quality and lower-cost healthcare. The Health Care Transformation Task Force includes some of the largest U.S. health systems, including Ascension, St. Louis, and Trinity Health, Livonia, Mich., and insurance giants Aetna and Health Care Service Corp. Employer Caesars Entertainment and the Pacific Business Group on Health are also part of the task force. Task force members said they would reach a deal by the end of the year. The task force are regional giants in the Midwest, including Ascension in Chicago. "We

RELATED CONTENT

- Medicare's payment reform push draws praise and fears
- Value-based care not likely to end payer/provider financial spats
- Reform Update: Some question the value of value-based purchasing

Care Integration and Coordination

Accountable Care Organizations (ACO):
Provider-Based governing body responsible for
provision of resources to meet the Triple Aim

Patient-Centered Specialty Practice
(PCSP): Coordinated Care

Patient-Centered
Medical Home
(PCMH):
“Whole Person”
Comprehensive
Care

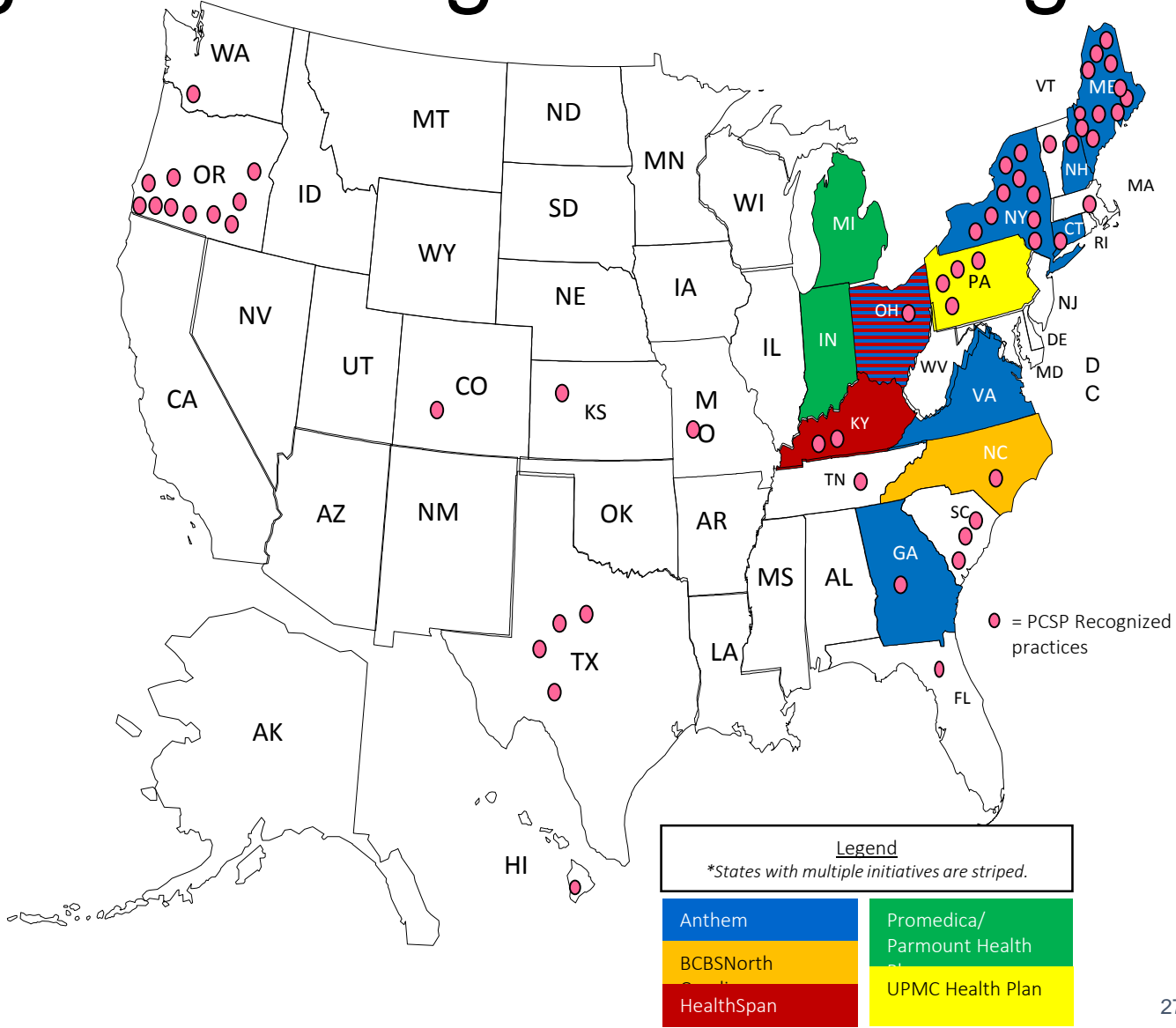
Why Coordination of Care?

- PCPs and specialists can **benefit from structure and guidelines** to establish and maintain good communication¹
- Effective collaborative arrangements may result in **reduction in use of unnecessary care**²
- **State and private payer PCMH initiatives** include specialists (e.g. VT, BCBSNC)

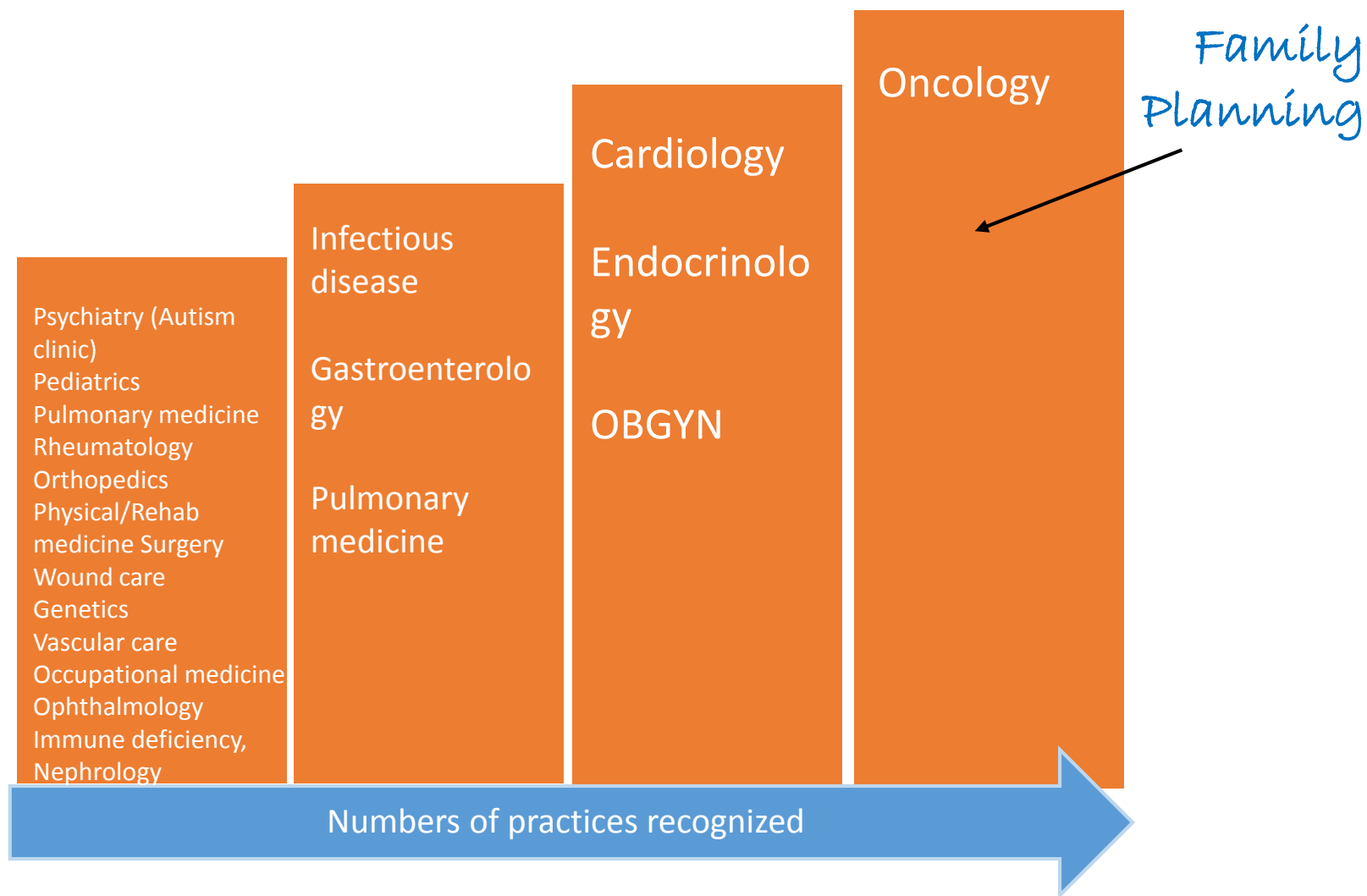
¹Peikes, D., Taylor, E.F., Lake, T., Nysenbaum, J., Peterson, G., Meyers, D. (2011) Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. AHRQ

²Foy, R., Hempel, S., Rubenstein, L., Suttorp, M., Seelig, M., Shanman, R., Shekelle, P.G. (2010). Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. *Annals of Internal Medicine*, 152 (4), 247-258.

Commercial Payer Incentives Programs Using PCSP Recognition



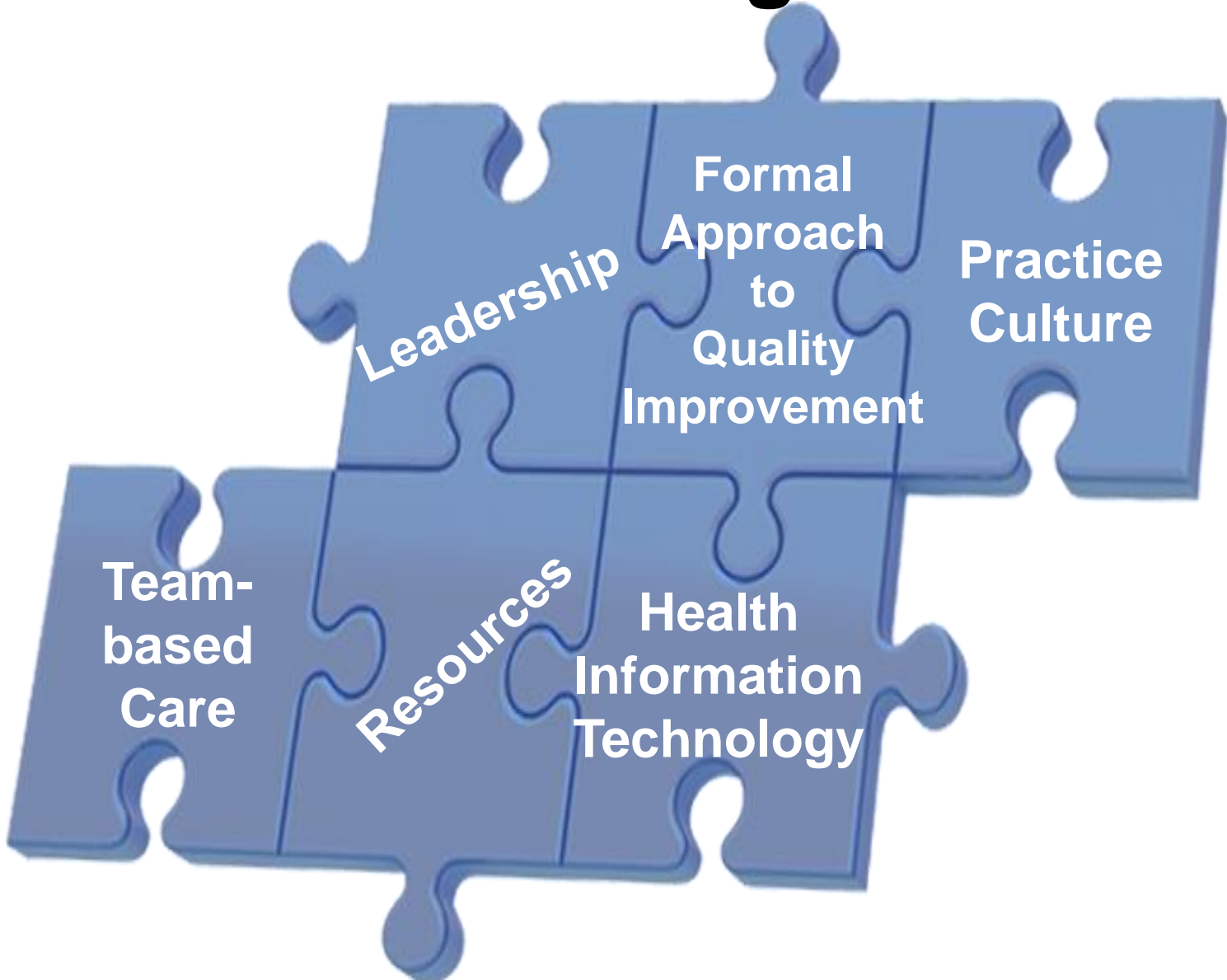
Recognitions by Specialty Type



Key Aims of the Program: Possible Challenges for Family Planning Practices?

1. **Patient access** (timely appointments and advice)
2. **Agreements** with PCP to coordinate care
3. **Timely** information exchange with PCP
4. **Timely referral summary** to referring clinician
5. **Care plan** coordination with PCP
6. **Communication** with patient and PCP
7. **Reduced duplication** of tests
8. **Measure** performance
9. **Alignment** with Meaningful Use Requirements

Lessons Learned: What does it Take to Achieve Recognition?



Why Become a PCSP?

- **Operational efficiency** Maximize the use of practice capacity
- **Cost reduction/avoidance Cover overhead** – the variable cost of additional office hours is almost exclusively labor costs.
- **Risk mitigation** Reduce the risk of legal liability through good documentation & adherence to policies/procedures > Lower malpractice insurance premiums
- **Value-based performance Prepare for reimbursement methods** (private & public) that pay-for-value (quality vs cost) > Enhanced payer reimbursement & Preferred Provider status
- **Employer of choice** Improve staff retention to avoid practice disruption (it is less expensive than hiring/training new staff)
- **Quality of Care/Practice of choice** Stand out in a competitive marketplace - Attract new patients and their families (while retaining current patients)

NCQA Contact Information

Visit NCQA Web Site at www.ncqa.org to:

- ✓ Follow the Start-to-Finish Pathway
- ✓ View Frequently Asked Questions
- ✓ View Recognition Programs Training Schedule

Contact NCQA Customer Support at 1-888-275-7585

M-F, 8:30 a.m. - 5:00 p.m. ET to:

- ✓ Acquire standards documents, application account, survey tools
- ✓ Questions about your user ID, password, access

For questions about interpretation of standards or elements to [My NCQA](#)

Select Policy/Program Support- Recognition Programs

Our PCSP Experience

Sandra Williams, MPA

Senior Director, MIC Women's Health Services



MIC WOMEN'S HEALTH SERVICES
A Program of Public Health Solutions

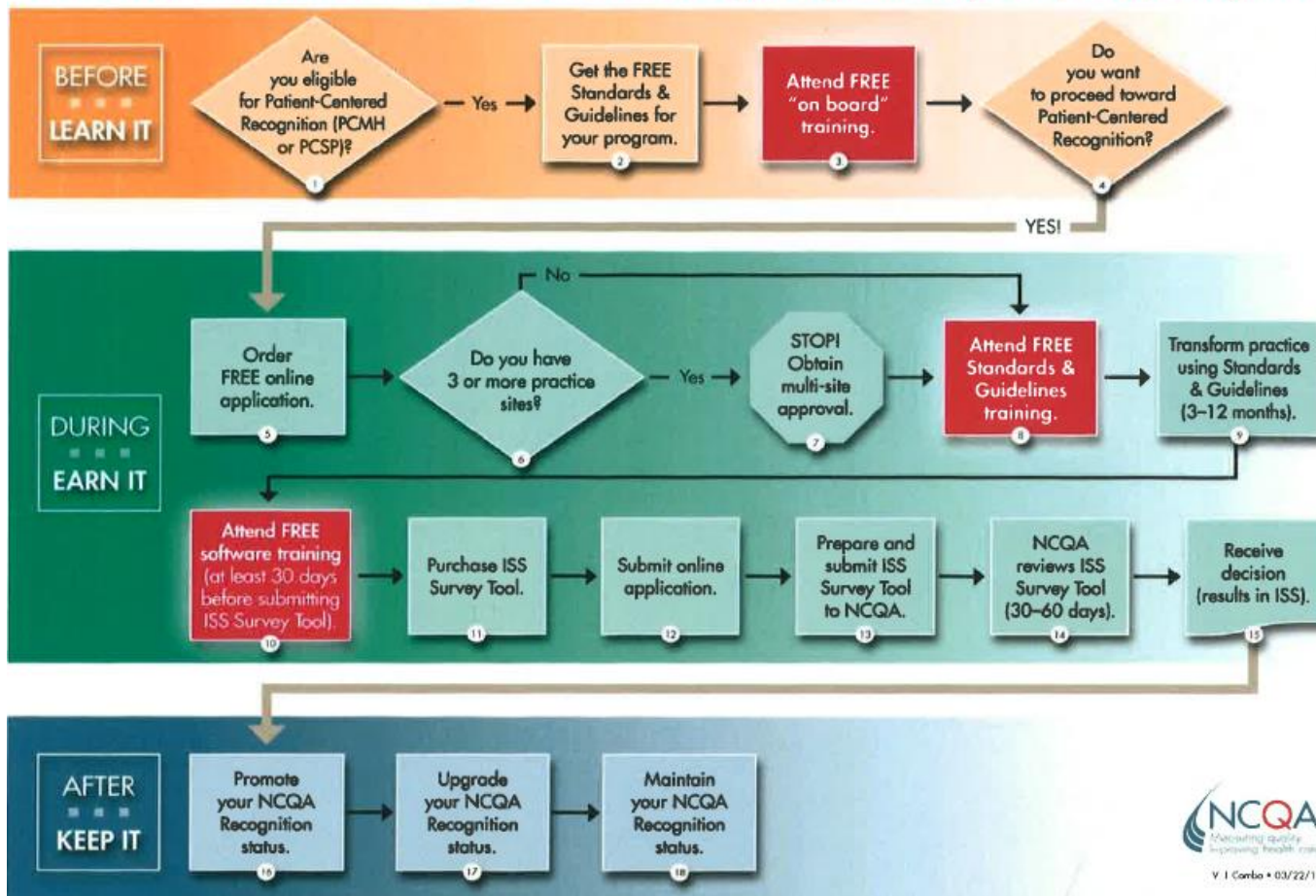
Objectives

- Understand the certification process
- Understand the organizational commitment:
 - Before, during, and after recognition

The PCSP Recognition Process

Start-to-Finish

Start to Finish: Patient-Centered Medical Home or Specialty Practice (PCMH/PCSP) Recognition



**APPENDIX 1
PCSP SCORING**

Scoring Summary

Recognition Levels	Required Points	Must-Pass Elements
Level 1	25-49 points	<ul style="list-style-type: none"> • 5 of 5 elements are required for each level • Score for each Must-Pass element must be > or = 50%
Level 2	50-74 points	
Level 3	75-100 points	

100 Points, 22 Elements, 5 Must-Pass Elements

Updated 3/25/2014

Points	Page	Standard/Element	Our Progress	11/25 Score	Upon Completion Percentage	Upon Completion Score
22		PCSP 1: Track and Coordinate Referrals				
9	27	Element A: Referral Process and Agreements	3/8- 50%	4.5	100%	9
5	31	Element B: Referral Consent	4/7- 75%	3.75	75%	3.75
8	33	Element C: Referral Response	5/8- 75%	6	75%	6
18		PCSP 2: Provide Access and Communication				
5	36	Element A: Access	6/8- 100%	5	100%	5
2	39	Element B: Electronic Access	1/6- 25%	0.5	75%	1.5
4	42	Element C: Specialty Practice Responsibilities	0/3- 0%	0	100%	4
2	43	Element D: Culturally & Linguistically Appropriate Services (CLAS)	4/4- 100%	2	100%	2
5	44	Element E: Practice Team	5/7- 100%	5	100%	5
19		PCSP 3: Identify and Coordinate Patient Populations				
3	47	Element A: Patient Information	11/14- 100%	3	100%	3
4	50	Element B: Clinical Data	9/10- 100%	4	100%	4
3	53	Element C: Coordinate Patient Populations	0/5- 0%	0	75%	2.25
18		PCSP 4: Plan and Manage Care				
11	55	Element A: Care Planning and Support Self-Care	1/8- 0%	0	100%	11
5	59	Element B: Medication Management	2/6- 25%	1.25	100%	5
2	61	Element C: Use Electronic Prescribing	2/5- 75%	1.5	100%	2
16		PCSP 5: Track and Coordinate Care				
5	64	Element A: Test Tracking and Follow-Up	8/11- 0%	0	100%	5
6	68	Element B: Referral Tracking and Follow-Up	2/9- 25%	1.5	75%	3.75
5	73	Element C: Coordinate Care Transitions	2/6- 50%	2.5	100%	5
16		PCSP 6: Measure and Improve Performance				
5	77	Element A: Measure Performance	1/5- 50%	2.5	75%	3.75
5	80	Element B: Measure Patient/Family Experience	0/4- 0%	0	100%	5
4	82	Element C: Implement & Demonstrate Continuous Quality Improvement	0/9- 0%	0	75%	3
2	84	Element D: Report Performance	0/3- 0%	0	75%	1.5
0	85	Element E: Use Certified Technology	3/7- N/A	-		
				43		89.50

KEY:

MUST PASS= 50% SCORE
POOR PERFORMANCE- FOCUS OUR ATTENTION
PASS
GOOD PERFORMANCE- STRENGTHS
MU= MEANINGFUL USE

Scoring

Assess sites
against
Standards &
Guidelines

PCSP Recognition Standards

- Track and Coordinate Referrals
- Provide Access and Communication
- Identify and Coordinate Patient Populations
- Plan and Manage Care
- Track and Coordinate Care
- Measure and Improve Performance

Our Approach

- 2 Sites
- Title X- Meaningful Use
- eClinical Works = EHR

Operational Changes

- **Administrative:**
 - More detailed information recorded, tracked (clinical guidelines, medication reconciliation)
 - Patient Portal
 - Update Referral tracking & EHR documentation
- **Clinical:**
 - Coordination/Management of Care

Organizational Commitment

- Dedicated team needed (multidisciplinary)
- Medical Provider-care delivery changes
- Financial commitment

Benefits

- Short-Term:
 - Improved communication with patients
 - Improved coordination with other physicians
- Long-Term:
 - Improve quality of patient experience
 - Create channels for more referrals, increase patient flow
 - Leverage for reimbursement contracts with Managed Care Plans

Challenges

- Staff time commitment
- Provider training
- Adequate monitoring of new processes

Tips

- Realistic Scoring
- Document Everything
- Watch 'How To' webinars
- Organize binder with standards, score sheets, webinars
- Schedule routine team meetings
- Implement tracking system
- Train staff early in the process
- Review current policies compared to standards

Thank you!

Sandra Williams, MPA

Senior Director of MIC Women's Health Services

swilliams@healthsolutions.org

Patient-Centered Specialty Practice

Adagio Health Inc. – Western PA Title X
Grantee

Linda Snyder, DrPH

A bit of history...

- Adagio Health was in the process of accreditation through the AAAHC
- NFPRHA's *Leadership Learning Collaborative* opportunity
- CDC/OPA – Quality Family Planning Guidelines

Comparing QFP with PCSP...

Title X Family Planning

- Social services and referrals to/from other agencies
- Coordination & use of referral arrangements with other health care providers
- Access / LEP / Needs Assessments
- Project evaluation and outcomes

NCQA - PCSP

1. Track & Coordinate Referrals
2. Provide Access & Communication
3. Identify & Coordinate Patient Populations
4. Plan & Manage Care
5. Track & Coordinate Care
6. Measure & Improve Performance


PCSP Corporate Application

- Numerous Adagio Health-owned medical offices throughout western PA
- Met eligibility requirements for submission of a corporate application
- Provided a list of 14 elements to address at the corporate level, with at least 9 being answered
- Score from corporate survey is transferred to each individual site as a baseline for their survey

The Adagio Health Process

- Core team of six senior staff
- Focused work began late spring 2014
- New Policy & Standards Manual (key policies July 2014, full manual October 2014)
- Selection of our “Flagship Office”

Staff Involvement

- Met weekly beginning July 2014 through survey submission in December 2014
 - Smaller teams identified to address certain elements and factors
 - Individual work on certain components
 - Summaries back to the team for review, discussion, approval
 - Corporate survey submitted late December 2014
- 
- Corporate
Process
Grid

Next Steps

- Submission of individual office-level surveys [likely 10-12 offices]
- Very targeted elements & factors selected to address in the individual office surveys
- Development of very specific and precise processes and clinical /operational pathways to address referrals in, referrals out, care coordination, and communication – formalized and measurable
- Individual office level trainings across the region
- Implementation & monitoring

Lessons Learned

- Ask questions – don't assume you completely understand what's required for documentation!
- Establish processes – step by step processes that clearly outline each step a staff takes in providing certain services
- Pay attention to data collection and set up your system – early in the process – to make sure you can track what's happening
- Network Network Network
 Talk to people who've gone through the process

Lessons Learned, page 2

- Establish a core leadership team
- Meet frequently & regularly – the PCSP process changes how you do business so it needs to be core to everything you do
- Recognize you might not meet all factors

Why the PCSP?

- Quality, Quality, Quality
- Better alignment with Quality Family Planning Guidelines
- Better care, better health outcomes, reduced redundancies
- Improved collaboration with other health care providers – could mean more referrals to our offices resulting in increased revenue
- Potential for improved reimbursements with third party payers

Questions?

