National Conference
NFPRHA 2015

Patient-Centered Specialty Practice Designation

#NFPRHA15

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 PSCP 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?

PCHM 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

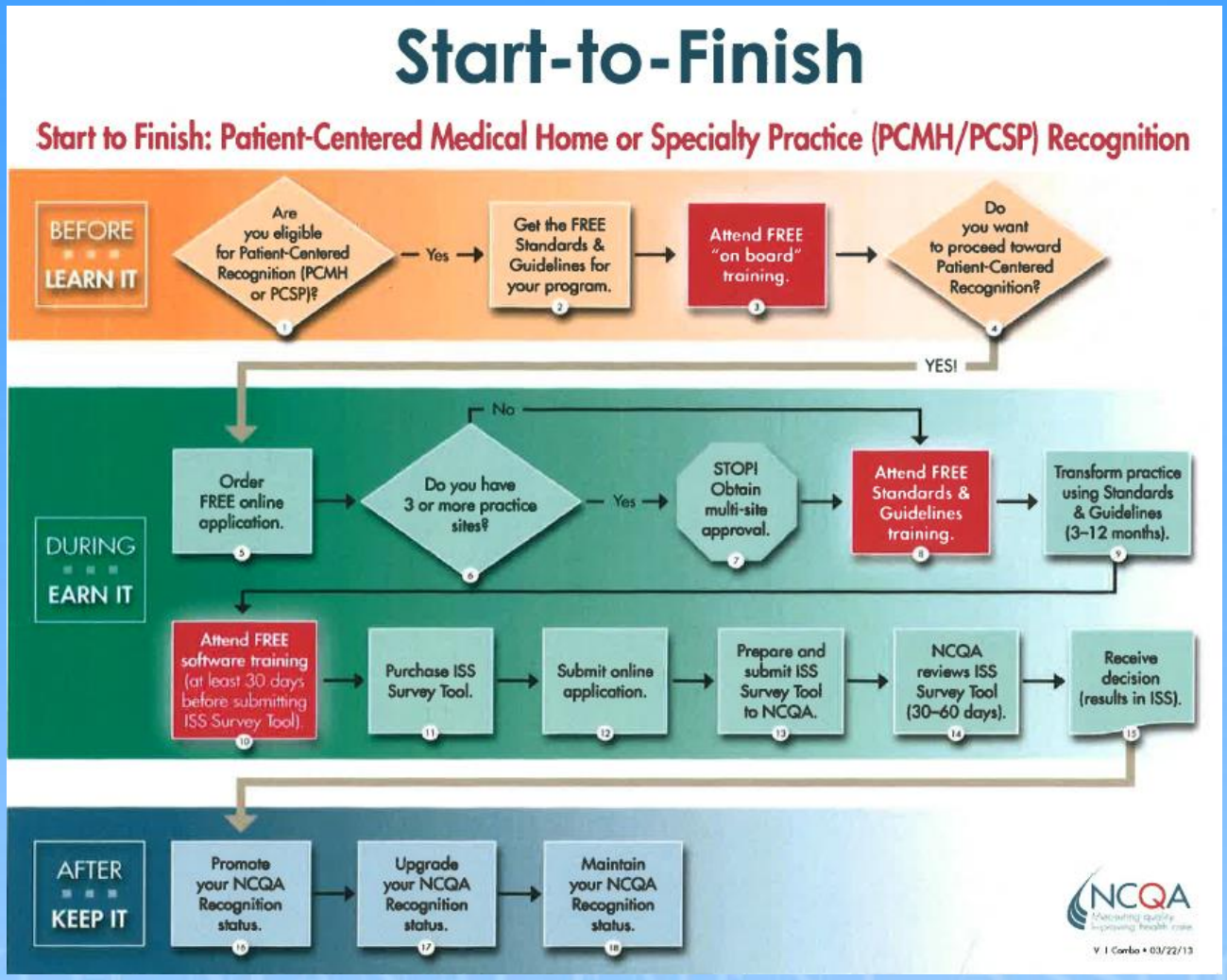
- Formal Approach to Quality Improvement

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?



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.	☐	☐
2. Specified methods of communication with PCPs and the referring clinician (if not the PCP).	☐	☐
3. Specified method of communicating with the patient/family/caregiver about specialist's plan of care.	☐	☐
4. Specified co-management or transition strategy for selected patients.	☐	☐
5. Confirmation of receipt and acceptance of referral with date and time of the appointment.	☐	☐
6. Specified information needed from referring clinician about patients.	☐	☐
7. Specified information and timing of the referral response to PCPs and referring clinicians (if not the PCP).	☐	☐
8. Type and method of communication with the patient and family/caregiver about results and treatment.	☐	☐

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

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

NCQA
Measuring quality. Improving health care.

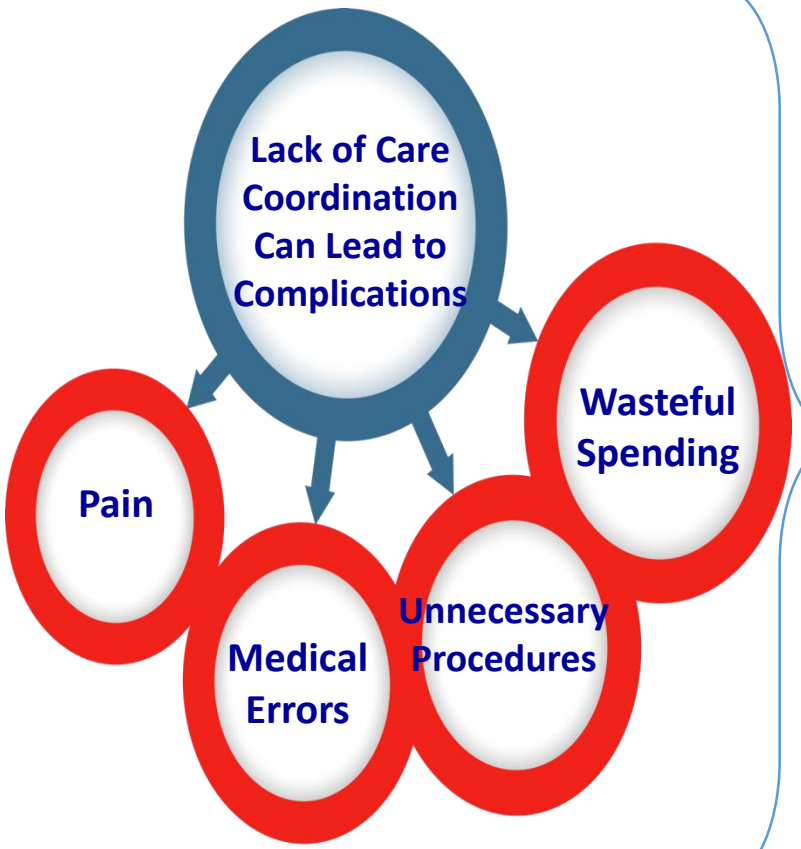
Atul Gawande on Fragmented Care…..

….”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

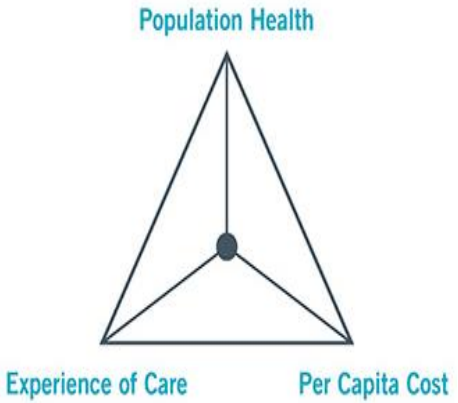
NCQA
Measuring quality. Improving health care.

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



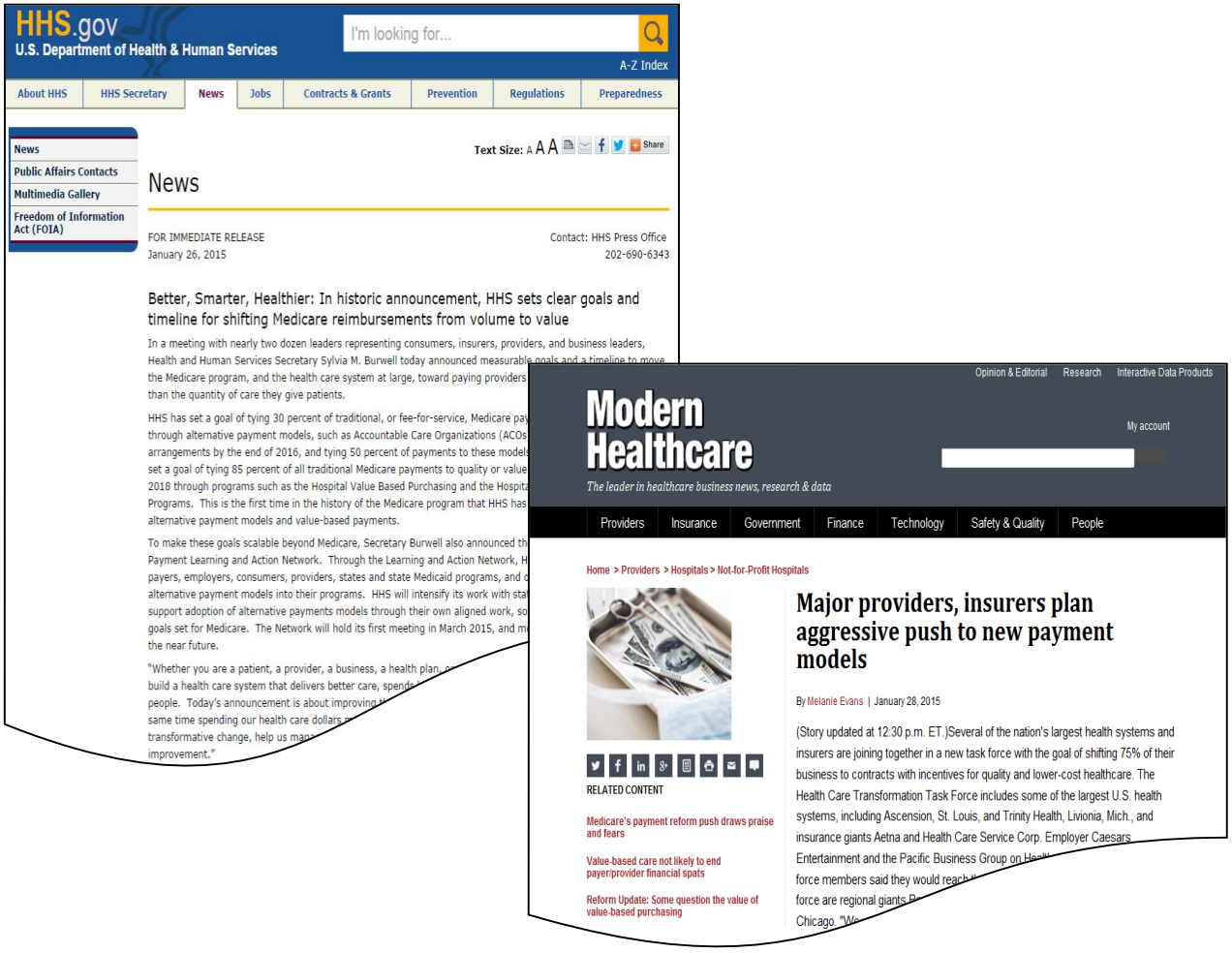
NCQA
Measuring quality. Improving health care.

The Medical Neighborhood is the answer…

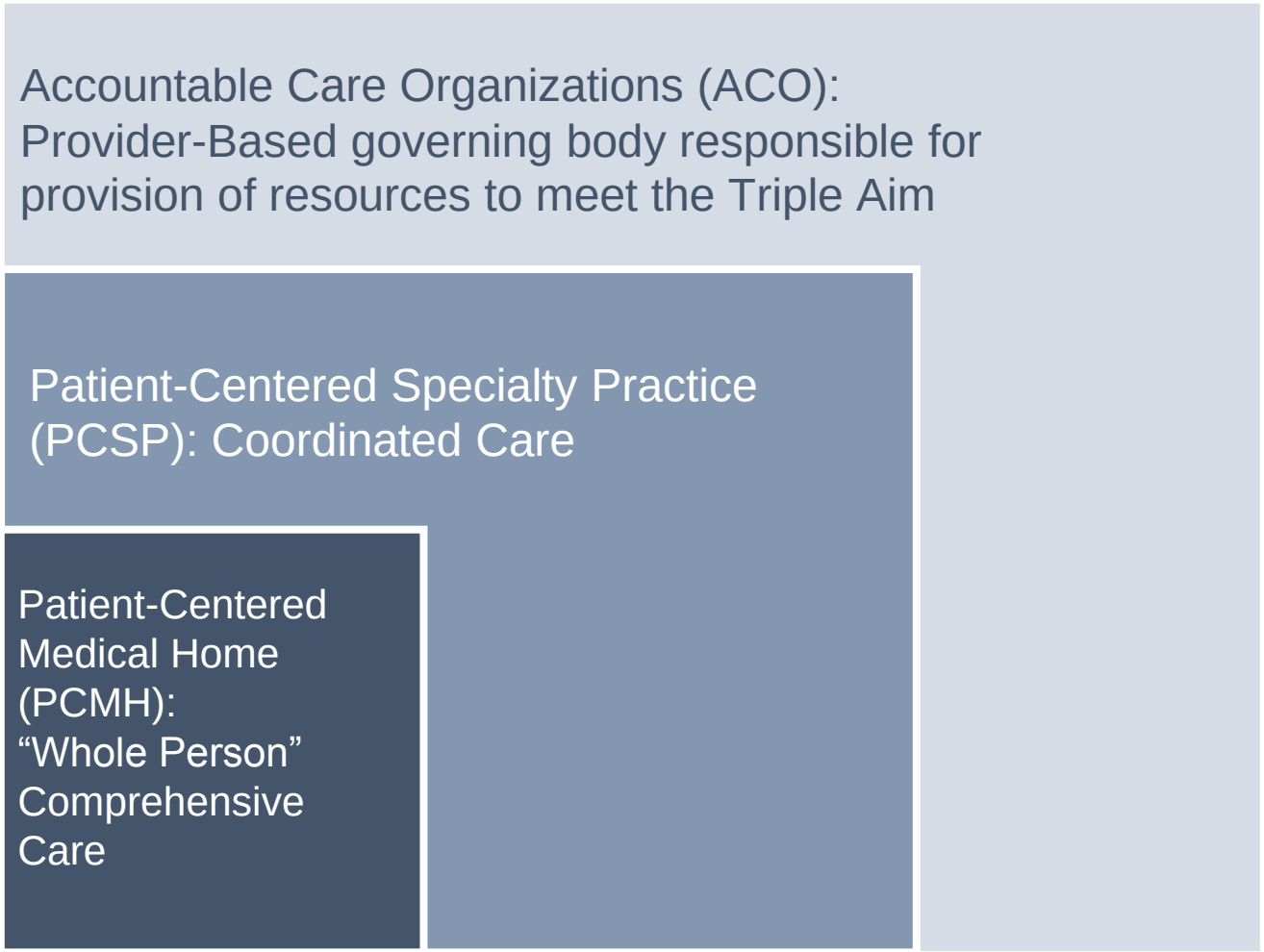
- **More efficient use of services**
  Lab, imaging, ER, hospitalization, return to PCP, systematic patient care management, EHR, generic medications
- **Improved patient experience**
  Access, coordination, clinician collaboration, involvement in care
- **Improved outcomes**
  Continuous quality improvement,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

NCQA
Measuring quality. Improving health care.

Future of Reimbursement- Payments Tied to Value



Care Integration and Coordination



Why Coordination of Care?

- PCPs and specialists can benefit from structure and guidelines to establish and maintain good communication[1]
- 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)

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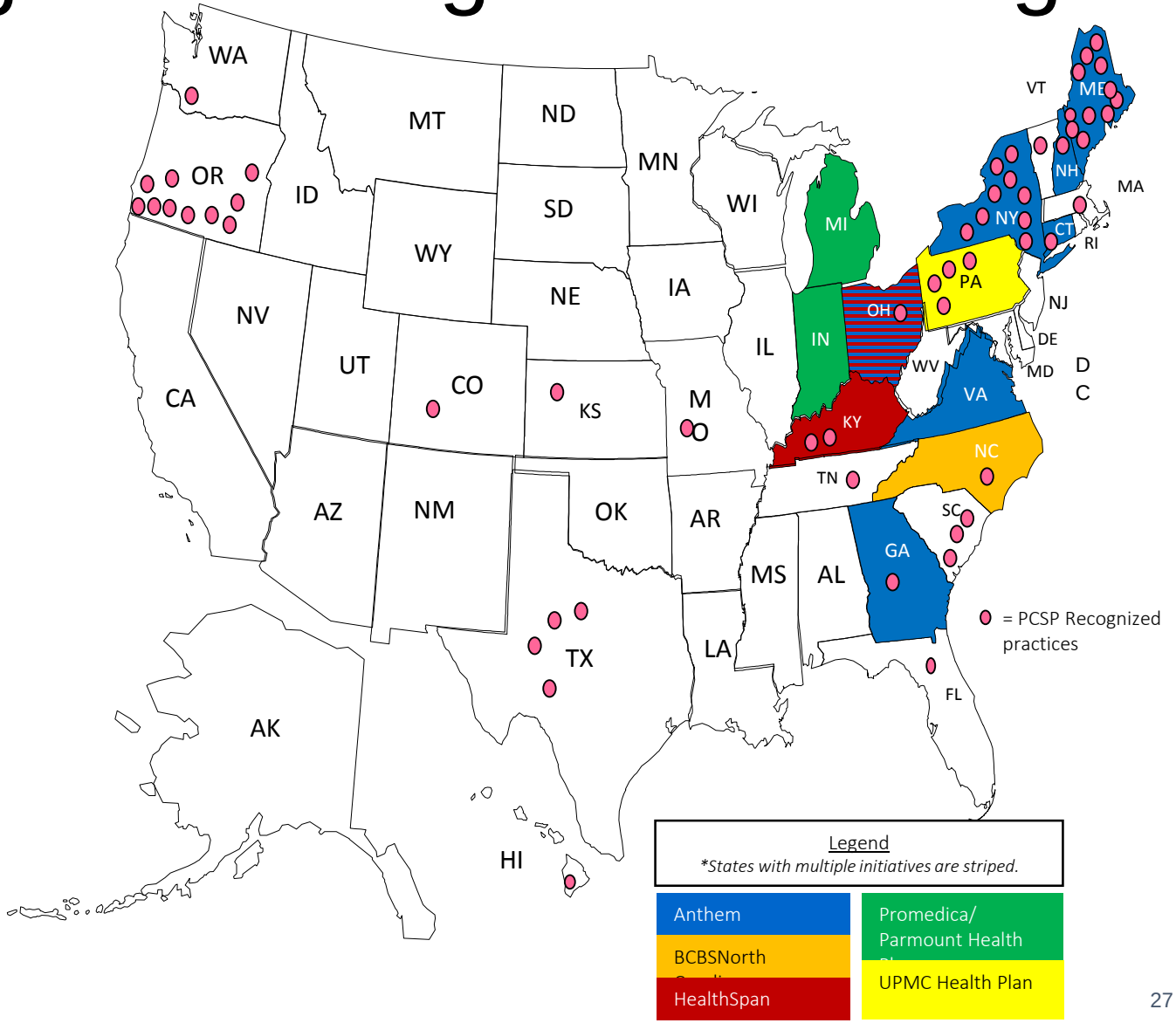
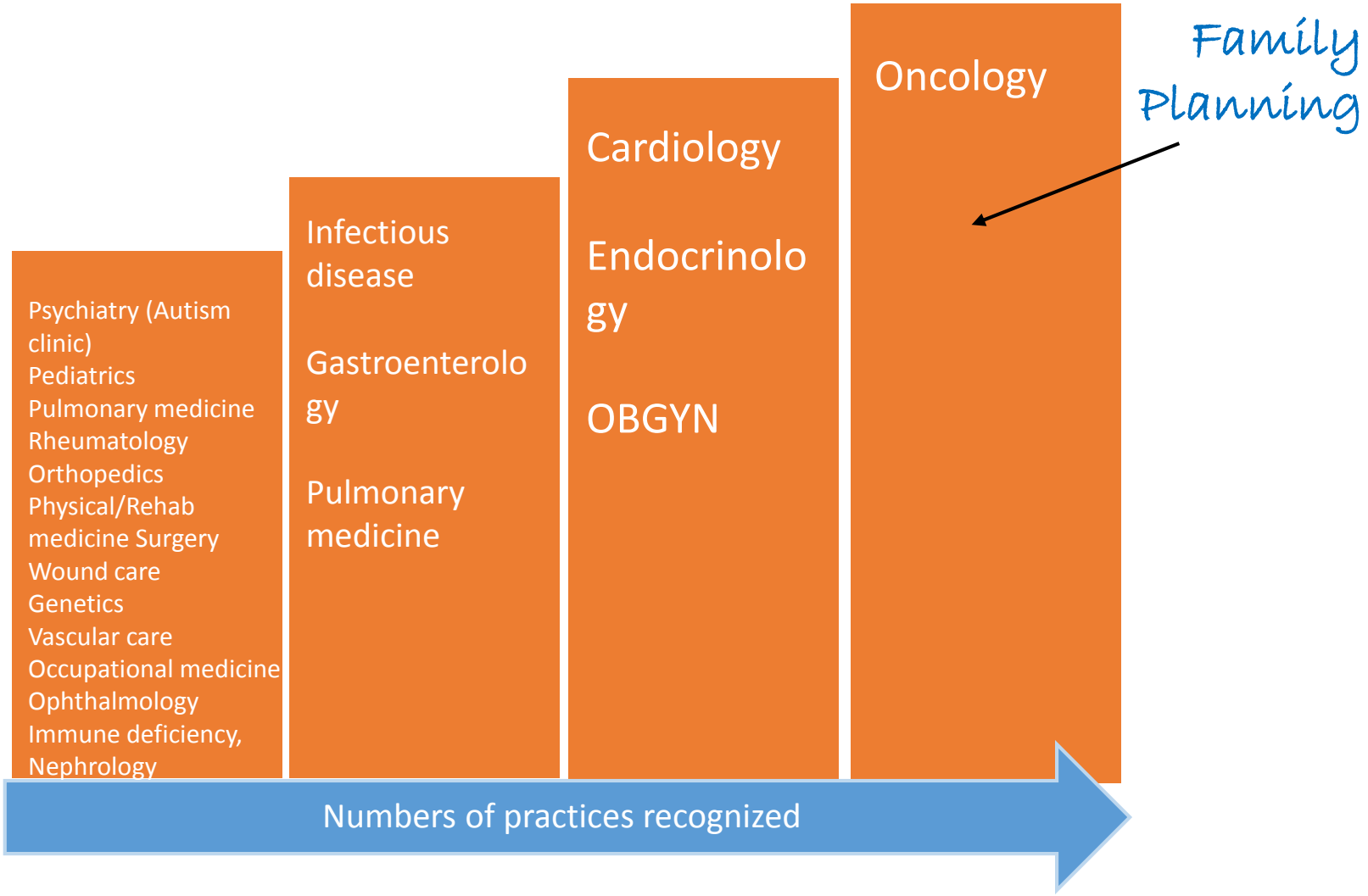
[1]Peikes, D., Taylor, E.F., Lake, T., Nysenbaum, J., Peterson, G., Meyers, D. (2011) Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. AHRQ

[2]Foy, 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 though 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

Public Health Solutions
MERGING RESEARCH AND ACTION

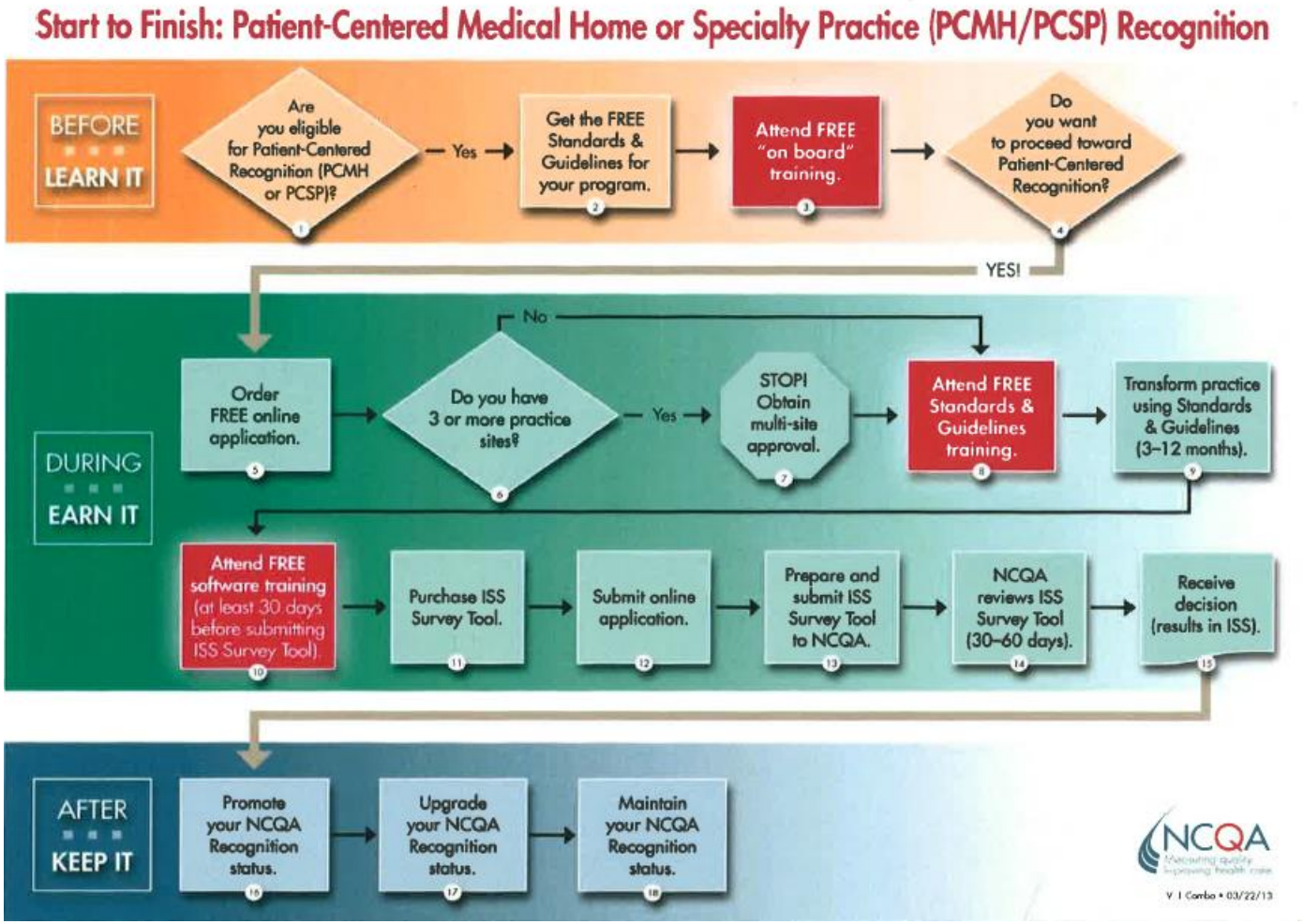
MIC WOMEN'S HEALTH SERVICES
A Program of Public Health Solutions

Objectives

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

The PCSP Recognition Process

Start-to-Finish



Scoring

Assess sites against Standards & Guidelines

APPENDIX 1
PCSP SCORING

Scoring Summary

Recognition Levels	Required Points	Must-Pass Elements
Level 1	25-49 points	• 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

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!

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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

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?