A Framework for Quality Improvement

Family Planning and Patient-Centered Speciality Practice Toolkit

National
Family Planning
& Reproductive Health Association

A Framework for Quality Improvement: Family Planning and Patient-Centered Specialty Practice Toolkit

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Introduction

The National Family Planning & Reproductive Health Association (NFPRHA) works to prepare and assist publicly funded family planning providers for the new health care economy accelerated by the Affordable Care Act (ACA). One of NFPRHA's top priorities is to help its members create a sustainable business model while maintaining a mission to provide high-quality health services to predominantly low-income and underinsured individuals. Achieving accreditation through the National Committee for Quality Assurance's (NCQA) Recognition Programs, which recognize health centers' commitment to providing efficient, effective, coordinated, high-quality, patient-centered care, is one pathway to advance sustainability.

NFPRHA, in collaboration with a consultant team, has created this toolkit to help its membership determine whether NQCA Patient-Centered Specialty Practice (PCSP) or Patient-Centered Medical Home (PCMH) Recognition is a good fit for their organizations. The step-by-step guide is specific to family planning organizations, supplemental to existing NCQA materials, and will support organizations to:

- make a decision about whether to apply for NCQA recognition;
- accurately and realistically plan for the budget, time, and resources needed for the application process;
- increase leadership and staff understanding of the benefits of NCQA recognition;
- anticipate and prepare for potential challenges of the recognition process; and
- increase familiarization with key NCQA resources.

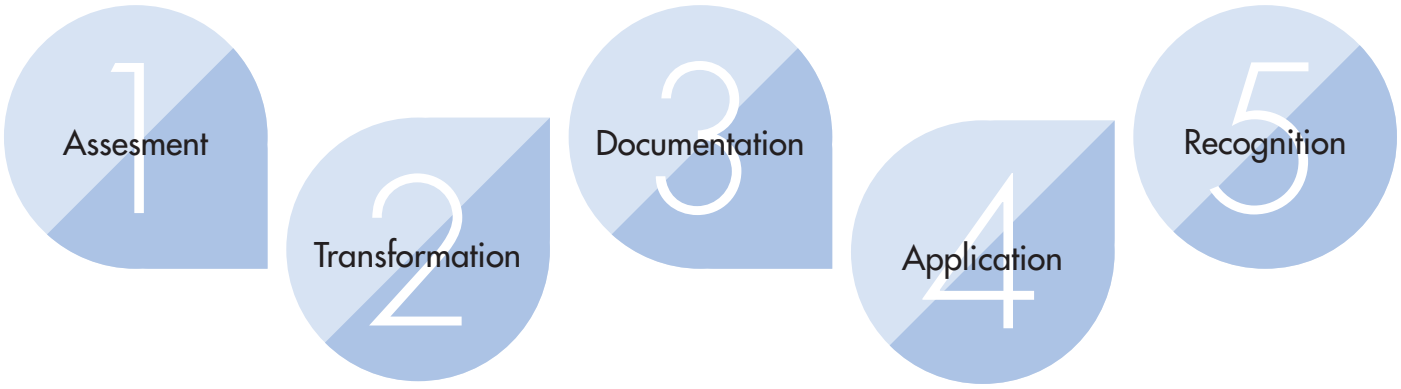
The toolkit draws upon the experiences of four NFPRHA member organizations that participated in a one-year Leadership Learning Collaborative (LLC) in 2013–2014 to learn, share, and practice problem-solving and strategic thinking with challenges related to the PCSP or PCMH Recognition process. Interviews were conducted with various staff members to learn about their experiences preparing and applying for NCQA recognition. Participants shared information about successful processes, challenges, resources needed, and recommendations for other organizations considering seeking NCQA recognition. The toolkit is also informed by knowledge gained by NFPRHA staff attending NCQA-facilitated, full-day trainings on PCMH and PCSP and direct input from NCQA staff. NFPRHA aims to leverage the lessons learned from these early adopters and development of internal expertise to support its broader membership in obtaining NCQA recognition.

LLC Participants

Organization Name	Location and Size	Recognition Type	Recognition Received
Adagio Health	Located in Pittsburgh, PA Serves over 100,000 women and their families every year in 55 sites across 27 counties	PCSP – multi-site	Application pending
Maine Family Planning	Located in Augusta, Maine Serves nearly 30,000 women and teens annually in 45 health centers statewide	PCMH – single site	PCMH Level 3
Public Health Seattle King County	Located in King County, Washington Serves approximately 12,000 individuals per year across 7 sites	PCSP – single site	PCSP Level 3
MIC Women's Health Services	Located in New York, NY Serves 4,500 low-income, high risk individuals annually	PCSP – two sites	PCSP Level 2

Toolkit Overview

As with any large initiative, it can be helpful to divide the PCSP Recognition process into smaller, more manageable sections. This toolkit divides the recognition process in five sections:



Before getting started, it is important to become familiar with the entire process, as each phase informs another and it may be necessary to work on more than one section simultaneously.

Each phase of NCQA recognition process involves three major types of work: tasks related to practice transformation (T), work to develop documentation (D) of processes, and tasks to gather documentation and apply to NCQA (A). The tools provided in this toolkit are attributed to these tasks with the following icons:

(T) = Transformation

(D) = Documentation

(A) = Application

Organizations pursuing either PCSP or PCMH Recognition can use the lessons learned during the application processes; however, the toolkit has a focus on PCSP Recognition as family planning organizations are more likely to meet NCQA's definition of a specialty practice and are thus better equipped to meet PCSP requirements.

The toolkit features checklists, charts, and guides to assist in various aspects of the recognition process, including project management tools shared by LLC participants or developed by NFPRHA and consultants. There are also NCQA-developed resources and information regarding how they should be used and, if applicable, how they may have unique relevance for family planning organizations. Appendix 1 outlines specific aspects of the application in more detail and contains examples of required documentation. Lastly, some tools are intended to be interactive or supplemental and are available for download at NFPRHA's website, nationalfamilyplanning.org.

The toolkit is not intended to replace NCQA's materials. Instead, it should be treated as a supplement and is specifically designed to help sexual and reproductive health providers. If there are differences between information in this toolkit and information in NCQA materials, consider the NCQA information to be authoritative. Additionally, examples of documentation should not be considered "templates" for documentation. Each organization's documentation will be different, because each organization is different.

Introduction to NCQA and its PCMH/PCSP Recognition Programs

NCQA is a private, 501(c)(3. not-for-profit organization dedicated to improving health care quality through measurement, transparency, and accountability. The NCQA Recognition Programs are a recognized symbol of quality earned by organizations that have completed a rigorous, comprehensive performance review process. Organizations that participate in NCQA's Recognition Programs, including PCMH and PCSP Recognition Programs, demonstrate excellence in health care delivery and the latest clinical protocols to ensure high-quality care.

In 2008, NCQA began the Physician Practice Connections®—Patient-Centered Medical Home™ (PPC-PCMH) Recognition Program. Revised in 2011 and 2014, the PCMH Recognition Program has become widely used by primary care practices to enhance care coordination and communication, with a focus on patient-centered care. The objective of the PCMH Program is to improve quality while reducing the redundancies and negative patient experiences associated with poorly coordinated care. To achieve PCMH Recognition, primary care practices must go through an application process and meet a set of standards. These standards ensure that practices have policies, practices, and systems in place, including electronic health record (EHR) systems, that support effective tracking and coordination of care. More than 11,000 practices throughout 47 states, Puerto Rico, and the District of Columbia have achieved PCMH Recognition.[1]

A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, reducing health disparities, and improving patient outcomes.[2] In addition, research shows PCMH-related activities deliver a solid return on investment (ROI). Pilot programs in Colorado found that for every dollar a health plan invested into PCMH payment incentives, the estimated ROI ranged between 2.5:1 to 4.5:1.[3] A positive ROI for payers is important to health centers, because it is evidence that increasing quality-based reimbursements is a good investment, which encourages more payers to offer similar incentives. Another study evaluating medical home programs in Arizona, Colorado, Ohio, and Rhode Island approximated that every dollar invested in care coordination activities produced $6 in medical cost savings in the third year of evaluation.[4] In addition, the number of states with private and public payer initiatives increased from 18 in 2009 to 44 in 2013.[5] These initiatives are growing in size, paying higher reimbursements, and engaging in more risk sharing with practices.[6]

Using the PCMH Program as the model, NCQA developed the PCSP Recognition Program for specialty practices. This new program, started in 2013, provides a framework for specialty care practices to partner effectively with primary care in delivering patient-centered care. Research reveals a great need to improve communication and coordination between primary care practices (PCPs) and specialists. For example, PCPs report sending referral-related information 70% of the time to specialists while specialists only report receiving information from PCPs 35% of the time. In addition, specialists report sending a report 81% of the time while PCPs report receiving a report just 62% of the time.[7] PCSP provides a structure to improve communication among PCPs and specialists.

> "Patient-centeredness and interconnectedness in the health care system is the way of the future."
>
> ~Evelyn Kieltyka, Senior VP Program Services, Maine Family Planning

In short, a PCSP recognizes specialty care that is coordinated, improves patient access, and increases patient-involved decision-making. The PCSP "Standards and Guidelines" (Standards) provide clear and specific criteria on organizing care around patients, working in teams, and coordinating and tracking care over time with primary care and other specialty care colleagues. Table 1 provides a summary of the 2013 PCSP Standards.

Table 1: Summary of NCQA 2013 PCSP Standards

Standard	Content Summary
PCSP 1: Track and Coordinate Referrals	• The practice has formal and informal agreements and specified methods of communication with PCPs and other referring clinicians. • The practice has a monitored process to track referrals that includes consideration of the urgency and type of referral. • The practice has a monitored process to ensure a timely response to PCPs, referring clinicians and patients.
PCSP 2: Provide Access and Communication	• To provide access, the practice has a written process, defined standards and demonstrates that it monitors against those standards. • Patients have access to culturally and linguistically appropriate services and clinical advice. • The focus is on team-based care with trained staff.
PCSP 3: Identify and Coordinate Patient Populations	• The practice collects demographic and clinical data for population management. • The practice assesses and documents patient risk factors. • The practice identifies patients for proactive reminders.
PCSP 4: Plan and Manage Care	• The practice assesses patient/family self-management abilities. • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources. • The practice reconciles patient medications at visits and post-hospitalization. • The practice uses e-prescribing.
PCSP 5: Track and Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals to secondary specialists and care at other facilities (e.g., hospitals). • The practice manages care transitions.
PCSP 6: Measure and Improve Performance	• The practice uses performance and patient experience data to continuously improve. • The practice tracks utilization measures such as rates of hospitalizations and ER visits. • The practice identifies vulnerable patient populations. • The practice demonstrates improved performance.

PCSP and Family Planning

PCSP Recognition provides a framework for change and a tangible set of guidelines and goals that can help family planning organizations modernize their practice to meet demands for high-quality, patient-centered care.

Title X-funded health centers are poised to meet NCQA's PCSP Recognition requirements in several ways. First, patient-centered care is a core value and mission of Title X providers. Second, Title X-funded health centers are experienced with adhering to program requirements and familiar with making changes to better serve patients. Finally, quality care is a cornerstone to the Title X program requirements and the Quality Family Planning (QFP) guidelines. Released in 2014, the QFP guidelines[8] and the 2013 PCSP requirements contain overlapping goals, including patient-centeredness, connecting with primary care, accessibility, and providing culturally and linguistically appropriate care. Therefore, PCSP Recognition provides an opportunity for family planning providers to receive acknowledgment for what many centers are already doing, and to leverage that recognition to strengthen relationships with patients, payers, and health care networks. Developed by NFPRHA, Table 2 highlights where the goals of the Title X requirements, QFP, and PCSP overlap.

"We were already doing a lot of work to be patient-centered, but it needed to be formalized."

~ Linda Snyder, Director of Evaluation and Strategic Analysis, Adagio Health

Table 2: Title X - QFP - PCSP Crosswalk

Quality Measure	Title X	QFP	PCSP
Accessibility	8.4 Clients must not be denied project services or be subjected to any variation in quality of services because of inability to pay.	Care does not vary in quality because of the personal characteristics of clients (e.g., sex, race/ethnicity, geographic location, insurance status, or socioeconomic status) (p. 4).	Standard 2, Element A, Factor 7: Provide equal access to accepted patients regardless of source of payment
Primary Care Engagement		These recommendations address how to remove barriers to contraceptive use, use the family planning visit to provide access to a broader range of primary care and behavioral health services, use the primary care visit to provide access to contraceptive and other family planning services, and strengthen links to other sources of care (p 2-3). For many women and men of reproductive age, a family planning service site is their only source of health care; therefore, visits should include provision of or referral to other preventive health services. Providers of family planning services that do not have the capacity to offer comprehensive primary care services should have strong links to other community providers to ensure that clients have access to primary care (p 20).	Standard 1: The practice coordinates patient care with primary care practices, referring clinicians, and patients to ensure a timely exchange of information. Standard 3, Element A, Factor 7: The practice records the name and contact information for the patient's current primary care clinician. If the patient does not have a primary care clinician, this should be recorded in the medical record. The practice is expected to encourage the patient to seek a primary care clinician and provide assistance as needed.
Quality Improvement	8.7 Planning and Evaluation Grantees must ensure that the project is competently and efficiently administered (42 CFR 59.5 (b) (6. and (7.). In order to adequately plan and evaluate program activities, grantees should develop written goals and objectives for the project period that are specific, measurable, achievable, realistic, time-framed, and which are consistent with Title X Program Requirements. The program plan should be based on a needs assessment. Grantee project plans must include an evaluation component that identifies indicators by which the program measures the Program Requirements for Title X Funded Family Planning Projects achievement of its objectives.	Service sites that offer family planning services should have a system for conducting quality improvement, which is designed to review and strengthen the quality of services on an ongoing basis. Quality improvement is the use of a deliberate and continuous effort to achieve measurable improvements in the identified indicators of quality of care, which improve the health of the community (p 21).	Standard 6: The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.

Quality Measure	Title X	QFP	PCSP
Patient Centeredness		These recommendations encourage taking a client-centered approach by: 1. highlighting that the client's primary purpose for visiting the service site must be respected, 2. noting the importance of confidential services and suggesting ways to provide them, 3. encouraging the availability of a broad range of contraceptive methods so that clients can make a selection based on their individual needs and preferences, and 4. reinforcing the need to deliver services in a culturally competent manner so as to meet the needs of all clients, including adolescents, those with limited English proficiency, those with disabilities, and those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ). (p 2).	Standard 2: The practice provides timely access to culturally and linguistically appropriate team-based clinical advice and care that meets the needs of patients/families/caregivers. Standard 3: The practice systematically records patient information and uses it to coordinate care for patient populations. Standard 4: The practice collaborates with the referring clinician and the patient/family/caregiver to plan and manage care and provide self-care support.
Culturally and Linguistically Appropriate Care	8.5.2 Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population (42 CFR 59.5 (b)(10))	Encourage taking a client-centered approach by reinforcing the need to deliver services in a culturally competent manner so as to meet the needs of all clients, including adolescents, those with limited English proficiency, those with disabilities, and those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ) Organizational policies, governance structures, and individual attitudes and practices all contribute to the cultural competence of a health-care entity and its staff. Cultural competency within a health-care setting refers to attitudes, practices, and policies that enable professionals to work effectively in cross-cultural situations (p 2).	Standard 2, Element D: The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families/caregivers.

Application Overview

Practices seeking PCSP Recognition must complete an online application and survey tool, and submit documentation of operational processes and capabilities to demonstrate the ability to meet the Standards. Each Standard contains Elements and Factors that are assigned a numerical value, which is used to evaluate the application. It can be helpful to think of the contents of the Standards as a series of building blocks:

Standard

- A fundamental quality concept.
- There are 6 PCSP Standards.

Element

- A specific aspect of the Standard.
- Some Elements are must-pass; an organization must score at least 50% on must-pass Elements to receive recognition.
- PCSP has 22 Elements; 5 are must-pass.

Factor

- A process, task, or metric that demonstrates quality.
- Critical Factors are of particular importance; Critical Factors within PCSP are mandatory to receive more than minimal points, or for some Factors, any points in an Element.
- PCSP has 155 Factors; 4 are Critical Factors.

In addition to scoring at least 50% on must-pass Elements, an organization must score a minimum of 25 out of a possible 100 points to obtain recognition. A summary of PCSP scoring is below. There are three levels of recognition; a higher score leads to a higher level of recognition. PCSP Recognition status lasts for three years.

Table 3: 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 ≥ 50%
Level 2	50-74 points	
Level 3	75-100 points	

100 Points, 22 Elements, 5 Must-Pass Elements

Points	Standard/Element	Must-Pass = 50% Score
22	**PCSP 1: Track and Coordinate Referrals**	
9	Element A: Referral Process and Agreements	✓
5	Element B: Referral Content	
8	Element C: Referral Response	✓
18	**PCSP 2: Provide Access and Communication**	
5	Element A: Access	
2	Element B: Electronic Access	
4	Element C: Specialty Practice Responsibilities	
2	Element D: Culturally & Linguistically Appropriate Services	
5	Element E: The Practice Team	✓
10	**PCSP 3: Identify and Coordinate Patient Populations**	
3	Element A: Patient Information	
4	Element B: Clinical Data	
3	Element C: Coordinate Patient Populations	
18	**PCSP 4: Plan and Manage Care**	
11	Element A: Care Planning and Support Self-Care	
5	Element B: Medication Management	✓
2	Element C: Use Electronic Prescribing	
16	**PCSP 5: Track and Coordinate Care**	
5	Element A: Test Tracking and Follow-up	
6	Element B: Referral Tracking and Follow-up	
5	Element C: Coordinate Care Transitions	
16	**PCSP 6: Measure and Improve Performance**	
5	Element A: Measure Performance	
5	Element B: Measure Patient/Family Experience	
4	Element C: Implement & Demonstrate Continuous QI	✓
2	Element D: Report Performance	
0	Element E: Use Certified EHR Technology	

Benefits of PCSP

While the proven benefits of PCSP are still being studied, the positive impact of PCMH is more established and the similar outcomes are expected in the PCSP Program. The number of practices using the PCSP Program to improve care is growing consistently, which means more practices are available to evaluate.

LLC participants reported the following benefits of applying for and earning PCSP Recognition:

1. Improved Patient Care and Coordination

Going through the NCQA recognition process can result in more time to work with complex patients, improve patient safety, and increase focus on outcomes and reduced duplication of services. New policies and procedures that meet PCSP Recognition Standards can build greater organizational capacity to treat the whole patient, including the capacity to monitor care received elsewhere, which is particularly important in a specialty practice such as family planning. LLC participants reported greater efficiency with work flows, increased collaboration among care teams, and improved patient care.

2. A More Favorable Standing with Insurance Plans

NCQA has built the Recognition Programs with a goal of helping specialty practices demonstrate to payers that they are innovative and committed to improving coordination, outcomes, and patient experience. These practices also convey to primary care providers an eagerness to be the best partners in caring for their shared patients. Practices that have attained PCMH Recognition have experienced higher reimbursement rates[9], and the PCSP Program is designed to help achieve the same results. It is anticipated that PCSP Recognition will be increasingly used by health plans to drive referrals to preferred sites of care and make care coordination payments available to specialists.

3. A Framework for Quality Improvement and Innovation

LLC participants found that going through the NCQA recognition process has increased overall readiness for other transformative care delivery and/or new payment models. PSCP Recognition offers a framework to support organizational change accelerated by health care reform. It is an opportunity for family planning health centers to be at the forefront of the innovations taking place in health care and position themselves as leaders in care transformation.

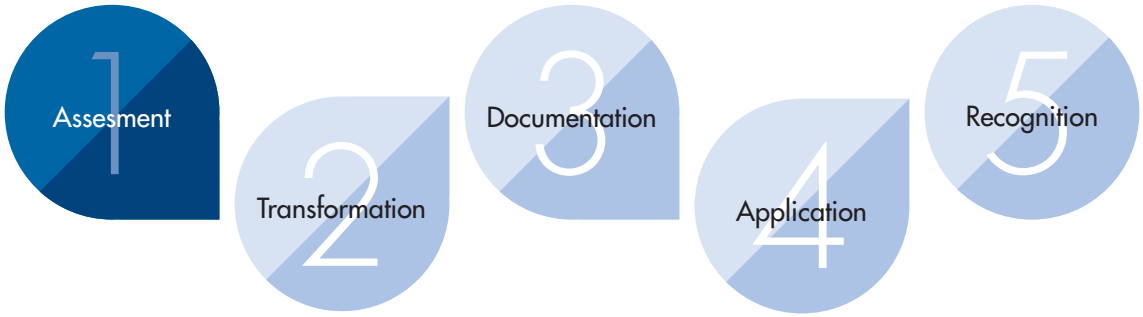
> "The LLC came at a time that put us ahead of the eight ball. I feel good that this is something relatively new and we're in it from the beginning."
>
> ~ Sandra Williams, Senior Director, MIC Women's Health Services

4. Development of New Partnerships

Close coordination among providers is a high priority, and LLC participants report that PCSP Recognition provides third-party validation of a practice's quality standards, increasing their credibility and recognition among patients, partners, and payers, which will help them develop or enhance a positive reputation in the community. Early adopters anticipate this recognition will help demonstrate the importance of family planning health centers to health care systems and neighborhoods, and their contribution to the overall health of a community.

5. Staff Professional Development

Front line staff report that, in the new health care era, they experience the most change and have the greatest opportunity for professional growth. To meet PCSP Standards, LLC participants provided training to staff, which afforded them the opportunity to learn new transformative protocols and processes. Staff learned new ways to more effectively organize care around patients, work in teams, and coordinate and track care over time with primary care and other specialty care colleagues. Through these new processes and trainings, staff had the opportunity to learn and grow.



Phase 1: Assessment

Taking time to assess the PCSP Standards and organizational readiness to achieve them will help leadership decide whether or not to pursue a specialty designation. This section provides information on three areas for assessment:

- Practice eligibility
- Application process
- Organizational readiness

1. Determine Practice Eligibility

The first step is to determine whether your organization is eligible to apply for PCSP Recognition. There are several types of eligibility to consider:

a. **Practice eligibility –** In PCSP, a practice is defined as one or more clinicians who practice together and provide care in the same geographic location. Practicing together means all clinicians follow the same procedures and policies; have access to all patient medical records, as appropriate; and electronic and paper-based systems and procedures support clinical and administrative functions;

b. **Clinician eligibility –** All applicants must have an unrestricted license. Doctors of medicine (MD), doctors of osteopathy (DO), advanced practice registered nurses (APRNs) and physician assistants (PA) practicing at a site with their own or shared panel of patients are listed with recognition. Clinicians should be listed at each site where they routinely see a panel of patients and be listed under multiple sites;

c. **Multi-site application eligibility –** Organizations with three or more sites that share policies and procedures and electronic systems across practice sites can request a streamlined multi-site application. Recognition is still given at the site level. As a result, a specified number of corporate (shared) elements are completed once and applied to multiple practice sites; all other elements require responses at the site level. Pre-approval for multi-site application is required; and

d. **Multi-specialty application eligibility –** Practices providing care for more than three specialties can request a multi-specialty application. Pre-approval is required for a multi-specialty application.

Adapted from NCQA resources, Tool 1 can help your organization identify decision points to use when considering eligibility.

PCSP Eligibility Guide

Practice Eligibility

- ☐ Should your organization apply for PCSP or PCMH Recognition?
- ☐ Does your practice meet the following criteria? (If yes, check box)
- ☐ clinicians who work together
- ☐ follow the same procedures and protocols
- ☐ share medical records
- ☐ have systems and procedures that support both clinical and administrative functions

If you checked yes to each criteria, your practice site meets important eligibility requirements for PCSP and/or PCMH Recognition.

Is 75% or more of the care your organization provides whole-person, patient-centered primary care?

- If yes, your organization is considered a primary care provider and eligible for PCMH. In this case, primary care refers to a basic set of comprehensive services rather than a patients' primary source of health care.
- If no and your organization provides care in nonprimary care specialties, it is eligible for PCSP.

Does your practice provide both primary care and specialty care?

- If yes, than your practice can apply for both PCSP and PCMH. In this case, all eligible clinicians who provide primary care would be part of the PCMH application, and all specialty care providers would be part of the PCSP application. Permission from NCQA is required to apply for both PCMH and PCSP.

Clinician Eligibility

Do you have clinicians that are eligible for PCSP or PCMH Recognition?

PCSP Recognition—Eligible Clinicians	PCMH Recognition—Eligible Clinicians
☐ Doctors of Osteopathy ☐ Nonprimary care specialty doctors of medicine ☐ Nurse practitioners, if they have/share a panel of patients ☐ Physician assistants, if they have/share a panel of patients ☐ Certified nurse midwives ☐ Doctoral or master's-level providers, who are board-certified, registered or licensed by the state to practice independently ☐ Psychologist ☐ Clinical social workers ☐ Marriage and family counselors	☐ Physicians ☐ Nurse practitioners who practice in the specialty of internal medicine, family medicine or pediatrics ☐ Physician assistants who practice in the specialty of internal medicine, family medicine or pediatrics ☐ Clinicians with the intention of serving as the personal, primary care clinician for their patients

continued>

PCSP Eligibility Guide (continued)

Multi-Site Eligibility

Does your organization have three or more sites applying for recognition and can answer "yes" to the following three questions?

1. Can you organization sign one PCSP program agreement to cover all sites applying for recognition?
2. For at least 3 months, have all applying sites shared medical records to document patient care for administration and billing?
3. For at least 3 months, have all applying sites operated under the same policies and procedures?
   - If yes, your organization should seek NCQA approval to submit a multi-site or corporate application, which can be done for both PCMH and PCSP.

Multi-Specialty

Does your site offer multiple specialty services?

- If yes, your organization must consult with NCQA before applying to determine whether your organization should submit a PCSP multi-specialty application.

LLC Lessons Learned: Eligibility

- Seek support from NCQA to determine if you should apply for PCMH, PCSP, or both.
- All eligible clinicians must be included in the application.
- If your organization is submitting a multi-site application, select a primary site with staff that is enthusiastic about the PCSP process. They can provide support and leadership as subsequent sites go through the transformation process.

2. Understand the Application Process

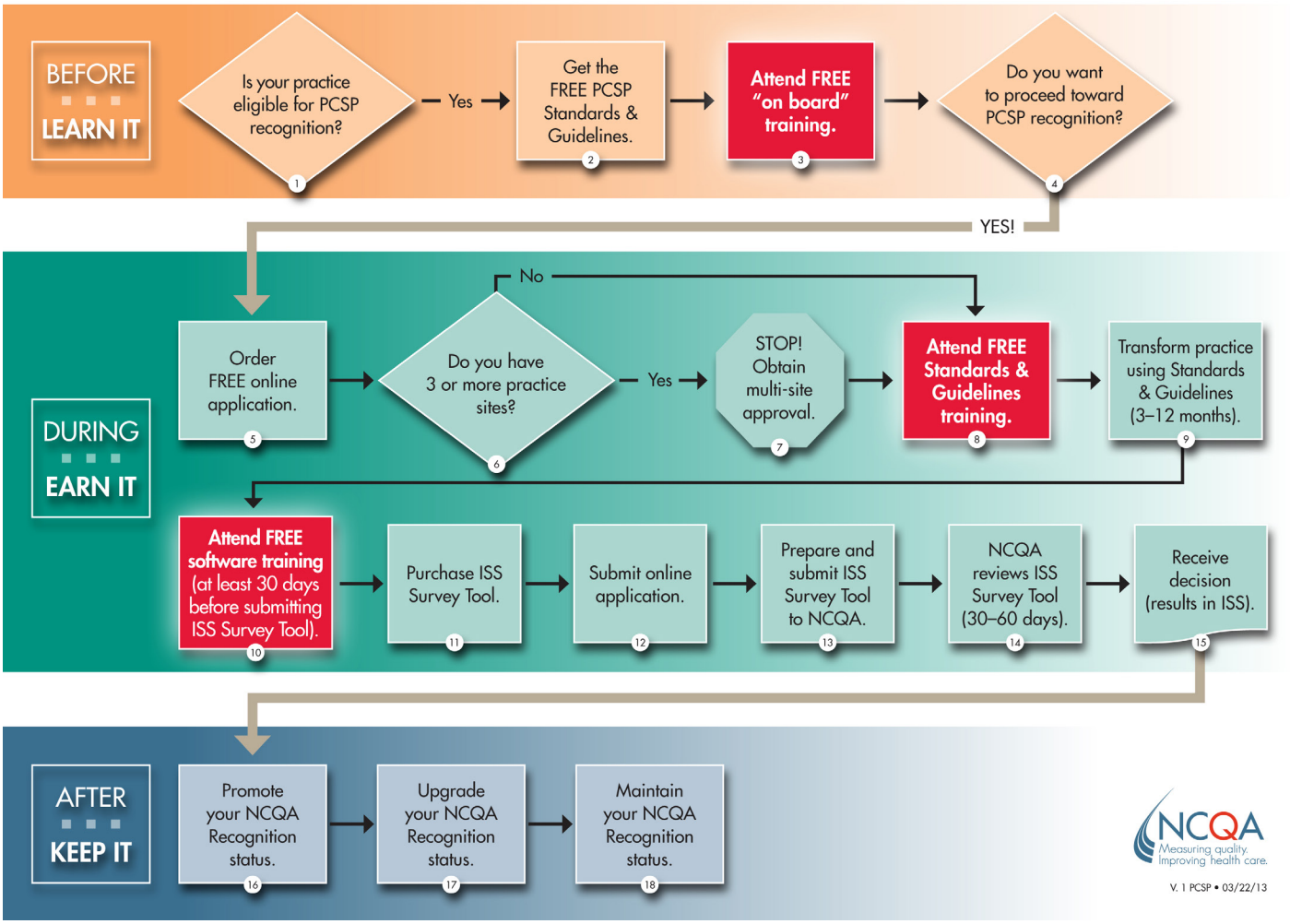
Conducting an internal and external organizational assessment is a logical first step when considering large operational changes. However, in the case of PCSP Recognition, taking a step back to fully understand the application process will ensure the assessment is informed and meaningful.

Transforming a practice to meet the PCSP Standards and organizing the application materials is an iterative process, with each Standard building on previous ones. LLC participants recommend leadership and project staff fully familiarize themselves with the specific requirements of the PCSP Standards and documentation. A thorough understanding of the process from the start is critical to inform an accurate assessment of needed changes, allotment of staff time and financial resources, and enables staff to identify the most efficient approach to meet each Standard, both in terms of practice transformation and creating, generating, and collecting the necessary documentation.

Tools 2–5 are designed to help organizations understand the application process.

Tool 2: Start-to-Finish Pathway to Recognition Chart (A)

NCQA's interactive web-based Start-to-Finish Flow Chart outlines the steps throughout the PCMH and PCSP application processes and can help your organization plan for a successful process. In addition, it highlights NCQA-developed resources for each step, like a series of free, introductory webinars. Live webinars are offered monthly, but recordings of the webinars are available any time. It may be useful to access the webinars more than once as content may be more relevant at different stages of the process.



Tool 3: Toolkit Supplemental Resources Chart (A)

This chart shows how the supplemental resources in this toolkit align with the steps of NCQA's Start-to-Finish flow chart.

Toolkit	NCQA Start-to-Finish Flow Chart	Tools
Phase 1: Assessment	Before – Learn It	Tool 1: Defining and Determining Eligibility (A) Tool 2: NCQA Start-to-Finish Flow Chart (A) Tool 3: Toolkit Supplemental Resources Chart (A) Tool 4: Understanding NCQA Survey and Application Submissions (A) Tool 5: How to Use the Standards and Guidelines (A)
Phase 2: Meeting the Standards Phase 3: Documentation Phase 4: Application	During – Earn it	Tool 1: Defining and Determining Eligibility (A) Tool 6: Internal Organizational Assessment (T) (A) Tool 7: Interactive Scoring Tool (T) (A) Tool 8: Build a Skilled Project Team (A) Tool 9: Effective Project Team Chart (A) Tool 10: Sample Letter to Primary Care Provider (T) Tool 11: Organizational Resource Assessment Guide (A) (T) Tool 12: Action and Decision Log (A) (D) Tool 13: TA Provider Selection Tool (A) (D) (T) Tool 14: Sample EHR Need Assessment (A) (D) (T) Tool 15: Documentation Check List (D)
Phase 5: Recognition	After – Keep It	Tool 16: PCSP Recognition Communications Checklist Tool 17: Sample Letter to Third-Party Payers

Tool 4: Understanding NCQA Survey and Application Submissions (A)

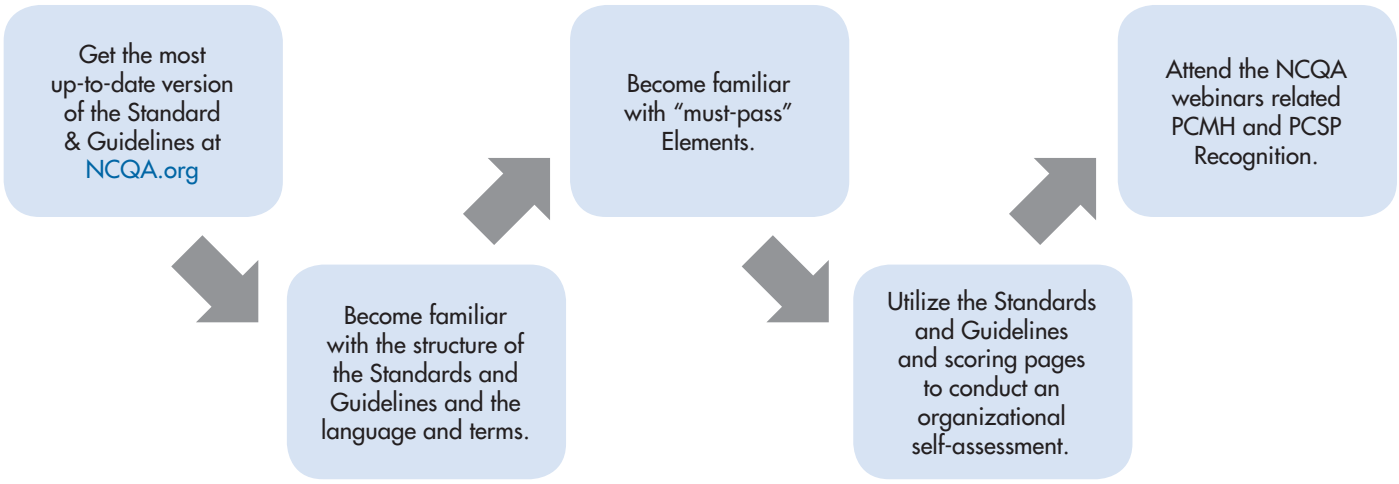
Your organization may submit materials to NCQA for review and/or approval up to five times throughout the application process. This chart is intended to ensure that these important steps are recognized and completed.

Application Material	Alignment With NCQA Start To Finish Flow Chart	Cost	Purpose
Order Online Application	Step 5	Free	The application collects organizational and/or site information, and e-signatures for program agreements. It also creates an online account for one or more practice sites. Completing the application notifies NCQA whether your organization is pursuing single or multi-site recognition. This application is used by NCQA to link your account with the Interactive Survey System (ISS) Survey Tool.
Multi-Site Approval	Step 7	Free	Organizations seeking multi-site recognition must first obtain approval. The online application allows an organization to specify that it wants to submit a multi-site application. This triggers an email response from NCQA requesting a phone call with your organization to discuss multi-site eligibility.
ISS Survey Tool	Step 11	$80 per survey license	The ISS Survey Tool is a software program used to review and score your practice. The survey tool will be used to collect information and documentation of how your site meets PCSP Standards throughout the 12-18 month transformation process. The purchase of the survey tool is the first of two payments made to NCQA.
Submit Online Application	Step 12	Free	The online application must be submitted at least five days before the ISS Survey Tool. NCQA reviews your application and notifies you in 1–5 business days that your application is linked to your ISS Survey Tool. Once you have received the link, you can begin completing the ISS Survey to include the documents required to show your PCSP features.
Survey Submission & Review	Steps 13 & 14	$550 -$6,600+	Each practice site has a separate application fee that is based on the number of clinicians who see patients. This is the second of two payments that will be made to NCQA. See NCQA PCSP Recognition Program Pricing for details.

Tool 5: How to Use the Standards and Guidelines (A)

The Standards should be used to guide practices through the transformation process. While this may seem like an overwhelming amount of information at first, once your organization begins to use it, you will likely find that it is an extremely valuable and well-organized resource.

This flowchart suggests how to most effectively and efficiently use the Standards and Guidelines.



3. Determine Organizational Readiness

Going through the PCSP Recognition process is not easy, and may not be suitable for every organization. It requires a high degree of organizational support, not only of the time required to apply, but of the potential transformation needed to meet the Standards. An early, objective self-assessment that clearly highlights areas for improvement is critical and can inform decision-making around time and resource allocation, and selection of staff for the project team.

Staff across the organization should be involved in the organizational assessment, from leadership to front line staff to clinicians, to ensure that all levels of the organization are ready to undertake the project. Organizational assessments of this nature can be informal, semi-structured meetings, or can be more structured, using assessment tools. Regardless of the process used, it is important to assess capacity, support, and existing resources thoroughly.

It is important for leadership to recognize the time and resources required for the process. Leadership will need to identify and support ways to help shift existing staff responsibilities so they may devote time to the recognition process. Some LLC organizations struggled with how to balance the PCSP Recognition process with the many other changes that are taking place in family planning and health care more generally. Communicating with staff on the purpose and benefits of PSCP/PCMH Recognition helped to build buy-in to devote the necessary time.

There are a number of self-scoring tools that can help organizations assess current process and protocols against PCSP/PCMH Recognition requirements and estimate the time and resources needed to successfully transform practices, develop new documentation or data collection, and gather documents to complete the application process. LLC participants reported that much more effort was needed to address the finer details of the requirements and that a more comprehensive assessment is important. In other words, health centers commonly find that documentation procedures, data reports, and internal processes need to be developed or tweaked to provide adequate evidence that the Standards are being met. Several examples of assessment tools are below.

"Using the scoring tool early in the process really helps assess where your agency is at, how to prioritize what to work on, and how much resource is needed to achieve chosen level [of recognition]."

~Heather Maisen, Family Planning Program Manager, PHSKC

Tool 6: Internal Organizational Assessment (T) (A)

Developed by HMA Community Strategies, this chart identifies important elements to consider when conducting an internal organizational assessment, which can guide decision-making on whether to pursue a recognition process. To help get a sense for your organization's readiness, rate your organization on a scale of one to five, one meaning that your organization lacks that component and five meaning that your organization has those criteria. Add up your score for each category to determine the extent to which your organization has the needed leadership, culture, staff capacity, and organizational capacity for the recognition process. The following scores indicate that your organization is a good position to begin the recognition process:

- Leadership – Score of 16 to 20
- Organizational Culture – Score of 12 to 15
- Organizational Capacity – Score of 20 to 30
- Staff Capacity – Score of 12 to 15

For those statements given a rating one, two, or three, work with the appropriate staff and/or board members to discuss a strategy for addressing the gap in information or resources. As noted above, this kind of tool can be used formally or informally, but a variety of organizational staff should be included in the conversation and assessment.

	Low				High
Organizational Assessment	**1**	**2**	**3**	**4**	**5**
Leadership					
There is strong leadership support for PCSP Recognition, including both executive leadership and the board (if applicable).					
Leadership understands the benefits of PCSP Recognition.					
Leadership is knowledgeable of the time and resources necessary for the PCSP Recognition application process.					
Leadership has approved the time and resources necessary for the PCSP Recognition application process.					
Total Score					
Organizational Culture					
Our organization's culture supports a patient-centered care philosophy.					
Our organization's culture supports the goal of care coordination.					
Our organization's culture is one that is open to and prepared for change.					
Total Score					
Organizational Capacity					
An electronic health records (EHR) system is in use.					
Our organization has implemented Meaningful Use.					
Our organization has a patient referral system is in place, either formal or informal.					
The time is right for the organization to pursue PCSP Recognition.					
Our organization's policies are written down and regularly reviewed.					
Our organization's protocols are written down and documented.					
Total Score					
Staff Capacity					
Our organization has a strong, detail oriented project manager who understands operations and who is available to manage the Recognition process.					
Our organization has a team of clinical, operation, IT, and financial professionals that is available to be a part of Recognition process.					
Staff have time and the expertise to provide training on new policies and procedures to other staff for PSCP Recognition.					
Total Score					

Tool 7: Interactive PCSP Scoring Tool (A) (T)

This interactive tool, adapted by HMA Community Strategies from NCQA materials, should be used as an organization first approaches the application process. Organizations often overestimate how prepared they are for the application. This tool identifies:

- which Elements and Factors are being met;
- where improvement is needed; and
- the time and resources required to complete the application.

It is important to score yourself on what evidence or documentation is available for each Standard, and not just on the perception that activity occurs to meet that Standard.

Below is an example of the tool and how it works. The full interactive tool is available for download at nationalfamilyplanning.org. The Scoring Sheet tab of the spreadsheet totals your score for each individual element.

Element 1A - Referral Process and Agreements *MUST PASS*			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	x	
2	Specified methods of communication with PCPs and referring clinician (if not PCP)	x	
3	Specified methods of communicating with the patient/family/caregiver about the specialist's care plan	x	
4	Specified co-management or transition strategy for selected patients		x
5	Confirmation of receipt and acceptance of referral with date and time of appointment		x
6	Specified information needed from referring clinician about patients	x	
7	Specified information and timing of referral response to PCPs and referring clinicians (if not PCP)		x
8	Type and method of communication with the patient and family/caregiver about results and treatment	x	

On the main tab ("Scoring Sheet"), enter a n "x" – into the "Yes" column for each element you believe you meet.

100%	75%	50%	25%	0%	Points Achieved
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	6.75

The score is automatically scored here

1 6.75

Element 1B - Referral Contents		5.00 points
The practice has a written process and monitors against it to ensure receipt of information needed in referrals from referring clinicians	Yes	No

The Total Score tab totals your overall score and indicates whether you have passed all must-pass elements.

Level of Qualifying	Points	Must Pass Elements (at 50% Performance Level)
Level 3	75-100	5 of 5
Level 2	50-74	5 of 5
Level 1	25-49	5 of 5
Not Recognized	0-24	< 5
Your Score	6.75	
Met Must Pass Elements	No	

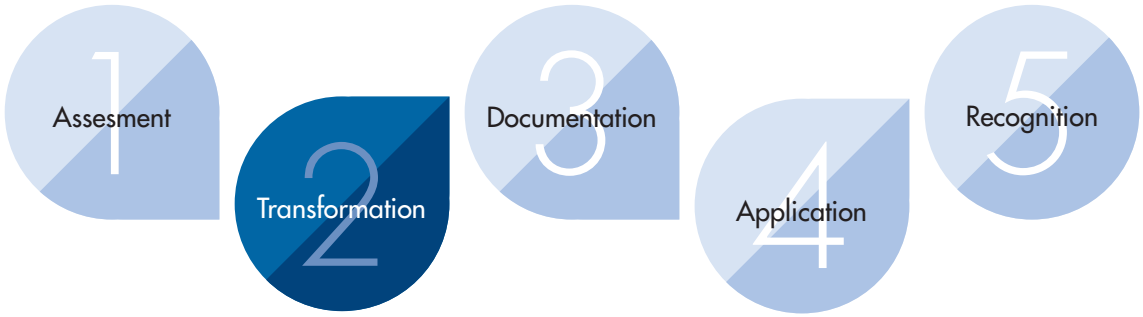
On the second tab ("Total Score"), your total score will be calculated for you, as will whether you meet the "Must Pass" elements.

LLC Lessons Learned: Organizational Readiness

- Assess and prioritize the must-pass Elements and Critical Factors to ensure there is enough time and resources to meet these aspects. If your organization can't meet these, you will not achieve recognition.
- Prioritize the Elements and Factors that will take longer to finalize and establish documentation (i.e. policy changes).
- Determine how other quality initiatives, like QFP, meaningful use, or PCMH, may align with PCSP Standards.

Additional Assessment Tools Available at nationalfamilyplanning.org

- **Strategic Questions Post Self-Assessment (A) (D) (T)** – Important strategic questions can guide the decision-making as to whether to pursue PCSP Recognition and how best to approach the application process. The project team, with leadership support and input, can use these questions to assess the organization's readiness for PCSP and the amount of resources needed, including time, to be successful.
- **PCSP – Meaningful Use Crosswalk (A) (T)** – PCSP Standards were developed to intentionally coincide with meaningful use requirements. As a result, family planning organizations that already attest to meaningful use standards will have a leg up in the application process. IT staff can use NCQA's meaningful use crosswalk to identify IT capacity and needs, relative to meaningful use and PCSP/PCMH standards.
- **2013 PCSP – 2014 PCMH Crosswalk (A) (T)** – The PCSP-PCMH Crosswalk is a document that shows what Standards are the same for both PCSP and PCMH Recognition. An organization that has earned PCMH Recognition can use this crosswalk to identify the PCSP Standards that coincide with PCMH Recognition and assess the extent to which new processes and documentation is needed to achieve PCSP Recognition.



Phase 2: Transformation

It can be difficult to create new protocol and document operational changes compliant with PCSP Standards. It takes time to educate and train staff on both the underlying concepts and culture change, and the new policies and practices. Providing this education and training early in the process is can help build interest in achieving PCSP Recognition.

Many family planning health centers already do much of the work needed for PCSP Recognition, so organizational leadership may assume the practice transformation, documentation gathering, and application process can be quickly accomplished. However, even organizations well on the path to meeting PCSP Standards will need time to make operational and administrative adjustments. The PCSP Recognition Program requires the documentation of any organizational change, which often requires alterations to many processes and protocols, as well as changes to data collection. In addition, new or revised processes must be in place for one to three months before data reports can be run.[10] Furthermore, staff training and behavioral changes can be gradual, so a practice should build in more time to assess new processes and provide staff feedback in order obtain data reports with more positive results. It is critical to consider how to successfully implement changes to leadership, teamwork, communications, measurement and other processes and protocols and how best to document these changes.

The transformation process is estimated to take three to 12 months; an additional three to six months can be needed for the application process. Early adopters estimate that the process can take as many as 800 staff hours, with teams of three to five people working together on a regular basis to write new policies, establish new protocols, train staff on these policies and protocols, make changes to EHRs, document the Standards and Elements, and gather the documentation to submit. Again, LLC participants found that much more time was needed than predicted to update policies and procedures.

A Team-Based Approach to Transformation

Taking a collaborative approach to the PCSP process allows staff to initiate this potentially new way of working together and ensures various staff expertise is available to meet each Standard. An effective team, led by a detail-oriented project manager who believes in the value of PCSP Recognition, should include staff with clinical, operations, human resources, quality improvement, and IT experience. The team is most effective when it includes members with different strengths, such as project management, policy development, staff training, organizing, formatting materials to help with documentation, and communicating with leadership on progress, decision-making, and resource constraints. Holding regular team meetings is a common approach used to discuss the process, what has been completed, and what still needs to be done.

In addition, teams should have the authority to make decisions regarding how to best change policies or processes to meet the PCSP Standards. Because the process is long and includes many components that directly impact staff at the clinical level, it is important to include staff members who can offer input on the best approach to meet the Standards. This may mean bringing some staff onto the team for a short time to help develop a policy or protocol to meet one specific Standard. For example, PCSP Standard 2, Element A requires health centers to have the ability to take same-day appointments. To meet this requirement and provide documented proof, an organization may need to change or write a policy, train staff on the policy, and change the appointment system to capture documentation of the process. In this case, it is helpful to have a staff member familiar with appointment policies and practices to help develop the policy, an IT staff member to help change the EHR, and a training expert to help develop staff training on the new policy.

Establishing a highly skilled team is critical to the success of PCSP Recognition. The following tools can help your organization identify who needs to be part of the PCSP transformation process and application team:

Tool 8: Build a Skilled Project Team (A)

These questions can help leadership assess the desired attributes and skills of the project team.

Team Skills and Attributes

- ☐ Does your team have strong organization and project management skills?
- ☐ Is your team knowledgeable about policy development?
- ☐ Does your team have the capacity to provide staff training?
- ☐ Is your team proficient in Microsoft Word, Microsoft Excel, and Adobe Acrobat Reader?
- ☐ Does your team have experience with formatting materials to help with documentation?
- ☐ Does your team have experience with scheduling and facilitating meetings?
- ☐ Does your team have strong communication skills, particularly with conveying progress, decision-making, and resource constraints to leadership?
- ☐ Does your team have enthusiasm for PCSP Recognition?

Developed by HMA Community Strategies

Tool 9: Effective Project Team Chart (A)

This chart outlines key characteristics, knowledge, and skill set needed by various types of staff.

Position	Characteristics	Knowledge & Skill Set
Project Manager	• Detail-oriented • Organized • Enthusiastic about PCSP Recognition • Can dedicate at least 50% of time	• Knowledgeable about operations • Authority to make decisions • Supervisor authority • Skilled in Microsoft Word, Excel, Adobe Acrobat Reader • Knowledgeable about document scanning and screen shots
IT	• Familiar with EHR system • Creative • Problem solver • Detail-oriented	• Can access needed data, reports, and systems, including billing, practice management, electronic prescription, electronic health records, and web portals, etc.
Quality Assurance	• Familiar with EHR system • Strong data collection and analytic skills	• Knowledgeable about identifying opportunities for work flow efficiencies and other functions related to quality
Clinic Staff/Provider	• PCSP champion • Strong leadership skills	• Knowledgeable about operations • Familiar with EHR
Human Resources	• Creative • A good listener • Strong communication skills • Detail-oriented	• Create/revise position descriptions
Executive Staff	• Strong leadership skills • A good listener and communicator • Supportive of time and resources required • Decision-ready	• Authority to allocate time and resources

Developed by HMA Community Strategies

LLC Lessons Learned: Building a Project Team

- The application team should include clinical staff that can provide input on how to improve processes, and have authority to make health center policy changes.
- Schedule days for the project team to work on PCSP application without interruption.
- Identify and reserve time for staff training on the new policies and protocols, paying particular attention to any new data collection processes.
- Identify a champion – someone who feels passionate about the project and can inspire and lead other staff members through organizational changes.
- Be prepared for staff changes throughout the long application process by having a contingency plan if anyone on the project team leaves. Ensure any changes in the project lead are communicated to NCQA, as an organization's NCQA account is linked to an individual staff email.

Project Management is Fundamental

NCQA recognition requires extensive project management to ensure a successful application. Documentation keeps the organization accountable for actually implementing each of the Factors and must be done for at least three months. Some Factors even require more than one document. For each Factor, it is important to determine the amount of resources needed, including time and effort, so that each piece of the application is completed in a timely manner. At the same time, many organizations will also be managing transformation in various aspects of their practice. Implementing and monitoring all of these changes requires strong project management skills.

"You absolutely need someone who's overseeing the entire process, because it's easy to get lost in the work."

~ Sandra Williams, Senior Director, MIC Women's Health Services

Tool 10: Organizational Resource Assessment Guide (A) (T)

This guide is one way to assess and allocate organizational resources to support the PCSP Recognition process. It can be used to identify the type of work and tasks to be done, and the team members who are best equipped to manage the work. For example, you might want to identify someone to read and understand the Standards, identify and prioritize tasks needed to meet each Standard, analyze where cross-over exists with other initiatives such as meaningful use, or identify important changes in work flow.

Organizational Resource Assessment Guide Purpose: Determine resources needed, time and effort, and time frame		
Type of Work	Tasks	Team Members and Lead?
Data	• Identify comprehensive list of data elements • Identify what is needed from EHR (documentation and other) • Design needed reports using information from EHR system • Write reports in the EHR (programming) • Data quality and assurance • Confirm EHR builds reports • Internal audit of reports to identify must-pass Elements and critical Factors and ensure documentation is accurate • Meaningful use reports • Patient Portal EHR implementation	
Training	• Conduct EHR training (retraining) relative to critical data entry/elements required to meet reporting needs • Train to new policies/procedures • Team communication and new roles relative to care coordination and referral management	
Administrative	• Develop forms used to meet the Standards, for example patient brochures or consent forms • Develop and implement patient communications, including letter and/phone call protocols and templates • Formatting documentation • Completing the application • Compiling evidence • Uploading the application	
Referral Management	• Staffing identified • Process identified	
Policies/Procedures	• Gap analysis of policies and procedures to identify what exists to meet standards • Identify, write, revise and/or document relevant policies and procedures	
Site-Based Team Development	• Assess support staff capacity • Coaching • Leadership development	
Other Primary Care & Family Planning Priorities	• Implementing QFP • Outreach and enrollment activities	
Adapted from Public Health Seattle King County		

Tool 11: Action and Decision Log (A) (D)

To assist with project management of the PCSP Recognition application, Public Health Seattle King County identified specific tasks and included them in an "Action and Decision Log." This was used at every project team meeting to assess progress. This example can be adapted to identify the specific type of tasks your organization needs to complete for the PCSP Recognition process.

Action and Decision Log					Status • As needed • In process • Pending • Complete
Meeting Date	Action/ Decision	Description	Person Responsible	Target Date	
Standards					
	A	Review of PCMH/PCSP Standards			
Documentation					
	A	Create a single/combined list of documentation elements			
	D	Review report list to determine how it can be used for NCQA documentation (i.e. is the report a documentation of a process or report showing evidence)			
	A	Send list of documentation needs to person managing documentation			
	D	Determine who will format/design reports and other documentation			
EHR Documentation and Needs					
	A	Create a single/combined list of what is needed from EHR System			
	A	Review the meaningful use reports.			
	D	Assess what report templates need to be developed			
	A	EHR Report update on progress			
Documentation Filing					
	A	Schedule time to review PCMH/PCSP folders together			
	A	Identify what new folders are needed and location of the folders			
	A	Populate folder and catalogue in PCSP/PCMH folder			
Data / IT					
	A	Send data needs report list to data team			
	A	Confirm timeframe of when data available			
Assess Resources					
	A	Identify data support from IT			
	D	Audit Planning: Assess amount of time that it takes to prepare and conduct internal audit of reports to meet standards			

Action and Decision Log					Status • As needed • In process • Pending • Complete
Meeting Date	Action/ Decision	Description	Person Responsible	Target Date	
Policy and Procedure Development					
	D	Policies and Procedure Assessment against the Standards			
	D	Develop list of PCSP/PCMH Policies procedures that are missing			
	D	Determine what key differences exist in current policies and process and revise			
	A	Review the current lab flow and determine follow-up needed			
	A	Assure the revision of lab processes includes Family Planning and Family Health			
Training					
	A	Schedule medical assistant training			
	A	Continue to address EHR training/support needs			
Human Resources					
	D	Determine job classification			
	A	Draft job description			
	A	Populate new folder with e-mails and newsletters that contain the EHR job aids			
	D	Identify who will help to create list and catalog of job aids			

LLC Lessons Learned: Project Management

- Devote more time early in the process to reduce stress at the time of submission.
- Incorporate time to work with NCQA from the very beginning and establish a relationship with your assigned NCQA representative.
- Identify a naming convention and common space to store documentation files to help with the final submission.
- Build in extra time to collect good data for the application, including time to train staff on data collection, assess implementation, and conduct additional training as needed.
- Identify dedicated physical space for project team to meet and work.

Additional Project Management Tools available at nationalfamilyplanning.org

- **Free Online PCSP/PCMH Project Management Tool** – BizMed Toolbox is one example of web-based tools that can help keep track of all the moving parts of the application process.
- **Meeting agenda for PCSP team discussion (A)** – An example of an agenda used by an LLC participant to organize meetings and ensure that all the important issues are discussed.
- **The Safety Net Medical Home Initiative: Transforming Care for Vulnerable Populations** – A research paper by the Safety Net Medical Home Initiative to find a replicable approach to support PCMH transformation among diverse practices serving vulnerable and underserved populations.

Transformational Changes

Early adopters saw positive changes as a result of the operational transformation needed to apply for PCSP Recognition. Overall, structural changes have helped organizations become more service-oriented for patients and efficient in operations.

> "The [PCMH] process requires a lot of quality improvement and tracking that will greatly improve the quality of patient care."
>
> ~Karla VanAlstine, Clinical Practice Manager, Maine Family Planning

Changes fall into three broad categories: 1. redefining staff roles and functions to increase emphasis on patient-centeredness and coordination; 2. increased teamwork and collaboration; and 3. IT systems changes.

Shift in staff roles and functions – Going through the PCSP Recognition process can raise awareness about how referral processes and patient care coordination can be improved or streamlined. For example, one organization changed staff job descriptions to include patient care coordination responsibilities. Making patient coordination a clear expectation of each position resulted in more effective work outcomes. As another example, one organization hired a new medical assistant to ensure sustainability of PCSP Recognition policies and protocols, including handling new care coordination expectations and documentation.

Increased teamwork and collaboration – Team-based practices are a must-pass requirement for PCMH, however organizations applying for PCMH and PCSP both saw greater internal collaboration emerge simply by going through the recognition process, transforming operations to meet the Standards, and becoming more aware of the need for and benefits of collaboration. LLC participants also reported increased and better communication with providers at other organizations, which was a direct result of the new policies and procedures implemented to meet PCSP Standards.

IT systems changes – Changes to EHR systems and data collection forms were necessary to provide documentation for each PCSP Standard. For example, organizations had to develop a new way to capture incoming and outgoing referrals and related communications. LLC organizations reported that this was a critical change, and one that was challenging to design and implement.

Tool 12: Sample EHR Needs Assessment (A) (D) (T)

This spreadsheet identifies the EHR capabilities and needs related to PCSP reports and documentation. This example from Public Health Seattle King County uses the EPIC system, but the form can be adapted to reflect any EHR platform. A portion of the tool is represented here, and the full spreadsheet is available for download at nationalfamilyplanning.org.

PCSP/PCMH EHR EPIC Needs								
EPIC Information (Job Aid, Workflows, Written instructions)	Date needed by	Assigned to	# of reports	EPIC/TRACKS Data Reports Needed	Date needed by	Assigned to	EPIC Demonstrated Capabilities (Screenshots)	Date needed by
Referral module - what data is collected and what is the flow?			1	Report of the number and data from the referrals received			EPIC can calculate a BMI	
Telephone Encounter - what data is collected and what is the flow?			2	Report showing date of referral received and date appointment was made			EPIC can plot and display growth charts	
Care team module - what data is collected and what is the flow?			3	Report of open and closed reports with dates of referral made and closed			Patient-specific checks for drug-drug and drug-allergy interactions	
Imms /MAR workflow			4	Generate a list of clients PCP and address if external			Alerts prescribers to generic alternatives	
Updated back office Lab Tests Job Aid			5	Provider patient panel reports - what information is provided			Exchange a summary of care document with a recipient that has a different EHR technology or conducts 1+ successful tests with CMS designated EHR	
Pre-visit planning job aid			6	Generate patient lists by due for specified services (ex. Had depo over 11 weeks ago or due for HPV vaccine)			Submit electronic data to immunization registries	
Overdue lab results module			7	Generate patient lists by specified conditions (ex. abnormal pap)				

LLC Lessons Learned: Transformational Changes

- Continually connecting operational changes to organizational mission can increase staff understanding and support for the work.
- Providing staff with a mechanism to provide input and feedback on changes can increase buy-in and engagement.
- Clearly defining roles and responsibilities of team members is fundamentally important.
- Pilot new policies to make sure they work within the clinical environment.
- New policies and procedures must be in place for at least 3 months before they can be submitted as documentation.

Patient Coordination and Referral

Patient coordination, including documenting and tracking ***incoming*** patient referrals, is fundamental to PCSP. This can be a specific challenge for family planning providers because the vast majority of patients are self-referred. In addition, Title X-funded health centers have federal requirements that hold them to a higher standard of confidentiality than other providers. If one does not already exist, providers should develop a process to track and report self-referred patients. This is not a requirement of PCSP, but this data is important for reviewers to understand the unique aspects of a family planning setting. However, the Standards stipulate that practices that often have patients who self-refer should have a written process for managing self-referred patients, including a mechanism for connecting patients who do not already have a primary care provider. In addition, an organization must have ***three*** examples of referral agreements that explicitly apply to ***incoming*** referrals. To maximize points, it is crucial that the agreements include the criteria outlined in Factors 2 -8 in PCSP Standard 1, Element A. Current agreements may need to be revised to add this information or increase the number of Factors covered (which increases the number of points that can be earned). New relationships and agreements with referring clinicians may take time to establish and should include as many Factors as possible.

Title X regulations require that documented consent is needed to share information, "…except as may be necessary to provide services the patient…" The Health Insurance Portability and Accountability Act of 1996 also allows protected health information to be shared for the purpose of treatment, payment, or health care operations.[11] However, Title X-funded health centers fill a unique role in the health care environment and many patients seen at them may assume their information is kept within the health center.[12] Patients should be asked if they would like their PCP to be informed of their care at the health center. Relationships and agreements with referring clinicians should include language notifying the PCP that the family planning agency will only share information with outside organizations when the patient has given consent.[13]

The transformation timeline may need to be extended to account for these tasks.

Tool 13: Sample Policy and Procedure for Self-Referred Patients (D) (A) (T)

Since the majority of patients seeking family planning and sexual health are self-referred, it is important to have policies in place on how to manage self-referred patients. This sample policy and procedure, adapted from Public Health Seattle King County, provides guidelines for engaging with a patient's PCP and assisting patients to find a primary care provider.

> "PCSP was a pathway to building an infrastructure to communicate and coordinate care with primary care providers."
>
> ~Heather Maisen, Family Planning Program Manager, Public Health Seattle/King County

Policy Title: Initiating Care Coordination with Self-Referred Patient's Primary Care Provider (PCP)
EFFECTIVE DATE: xx/xx/xxxx

Purpose:

To better coordinate care between family planning specialty provider's self-referred adult patients and their primary care providers to improve patients' health outcomes and reduce duplication of services.

Staff Responsible:

Family planning clinic staff: clerical, medical assistants, nurse practitioners, and site management team.

Policy:

1. For all self-referred adult (18 years old and older) patients, who have not exercised their right to restrict communication with primary care providers, family planning health centers will initiate contact with the patient's primary care provider to provide pertinent health information for the care managed by the family planning clinic to initiate care coordination.
2. Exclusions from this policy, include:
   - Teen patients (under 18 years old) are excluded from this policy due to their heightened need for confidential services.

APPROVAL

_____ _____

Signature, Program Manager Date

_____ _____

Signature, Medical Director Date

continued>

PROCEDURES:

Step 1: Identifying Patient's Primary Care Provider (PCP) – Clerical Staff

Staff responsible: Clerical staff performing check-in

Action: At check-in, clerical staff will enter adult patients' primary care provider (PCP) information:

- For new adult patients:
  - Ask the patient for their doctor or medical provider's name - where do they go when they are sick?
    - If they don't know the name of the doctor, please ask for the health center's name, location and address or contact information
  - Enter PCP information into EHR, per the EHR <Health Center> Family Planning Front Desk Job Aid
    - If the patient says an emergency room or urgent care, do not enter any PCP and treat as a patient who does not have a doctor or medical provider, see below.
  - If a patient does not have a doctor or medical provider
    - Refer to <primary care provider>, if eligible per primary care clinic
    - Otherwise, please give the patient the <health center> brochure < link provided>
- For established adult female patients:
  - Look-up PCP information
  - If blank, treat as a new patient
  - If PCP is entered, verbally confirm with patient the information is still current and accurate
  - At every visit confirm the PCP information is up-to-date and enter new information

Step 2: Informing Patients of Family Planning Services and Provider Communication Process

Staff responsible: Clerical staff performing check-in and medical records

Action: At check-in, clerical staff will:

- Distribute the family planning clinic brochure to adult female patients the <Health Center> family planning clinic brochure, "Welcome to <Health Center>"
- Inform adult female patients we will communicate with their primary care provider about your visit. Use the following script below with patients:

  "We want to better coordinate your care with your doctor. After your visit, we will write a letter telling your doctor about your visit today, including why you are here, and test results or birth control given."

  "If you do not want us to tell your doctor about your visits or if there is certain information you do not want us to share with your doctor, please tell us and you will need to fill out a form."

  "Do you want to fill out the form to not tell you doctor about your visits?"
- In accordance with the Notice of Privacy Practices (NOPP) from the Administrative Client Processes (ACP), have the patient fill out question #1 and sign the "Request to Exercise Client Rights" form.
- Clerical staff will enter a "release restriction" patient FYI flag per EHR <Health Center> Family Planning Front Desk job aid.
- Clerical staff will send the "Request to Exercise Client Rights" form to medical records.
- Medical records will scan the form into the EHR and then process the form according to <Health Center Policy>.

continued>

Step 3: Communication to PCP

Staff responsible: Nurse Practitioners and Medical Assistants

Actions:

- Producing letter to PCP – Nurse Practitioner
  - Before drafting the letter to the patient's PCP, confirm there is not a Patient FYI Flag: Release Restriction in the patient's chart. If there is one, do not write a letter.
  - Complete the EHR letter encounter titled, <XYZ>. The letter will have pulled all pertinent patient and clinic visit information, see template.
  - Route the letter to the MA for the MA to then process the letter.
- Processing letter – Medical Assistant
  - Letters will be printed on <Health Center> letterhead and mailed out or faxed to the primary care provider within 3 business days from receipt of lab results from the visit. If there are no labs, the letter will be sent out within 3 business days from receipt of the letter for processing.
  - When a letter to a patient's PCP is created, a referral will be entered into the EHR for tracking purposes, including the date when the letter was mailed or faxed.

Step 4: Handling Non-Deliverable letters

Staff responsible: Medical Records and Medical Assistants

Actions:

- For unopened returned letters:
  - Medical records receive the letters, and process per Returned Mail procedure, see Returned Mail Documentation EHR Job Aid
  - Medical records sends the MA an in-basket message that letter was returned for X patient
  - Medical Assistant will enter into referral module that letter was undeliverable
- For undeliverable faxed letter:
  - Medical Assistant will enter into referral module that letter was undeliverable

Step 5: PCP Responses

Staff responsible: Medical Records, Clerical Staff (front desk and call center) and Nurse Practitioner

Actions:

- PCP sends a response letter sent to Family Planning Provider
  - If a PCP sends a letter to family planning provider, medical record staff will give the letter to the Nurse Practitioner for review.
  - The Nurse Practitioner will review the letter and sign it, and send back to Medical records.
  - Medical records will document scan the letter into correspondence.
- PCP calls to Family Planning Provider
  - Clerical staff at the front desk or in the call center will write a telephone triage note in EHR attached to the patient's chart.
  - Staff will not transfer calls to providers.

continued>

Step 6: Family Planning Providers reply to PCP response

Staff responsible: Nurse Practitioner, Medical Assistant

Actions:

- Nurse Practitioner reviews letter or triage note and responds to PCP according to PCP's indicated preferred method of communication (i.e letter or phone) within 5 business days.
- Nurse Practitioner will document communication with PCP in a letter encounter or telephone encounter attached to patient's chart.
- Nurse Practitioner will route or send an in-basket message to medical assistant.
- Medical Assistant will update information in the referral module.

Tool 14: Sample Letter to Primary Care Provider (T)

Self-referred patients present an opportunity to build relationships with primary care providers by both connecting patients in need of a PCP and through improving coordination with established providers. Adapted from Public Health Seattle King County, this sample letter initiates patient coordination and encourages future incoming referrals with a PC.

<Family Planning Provider>
<Address>
<Phone number>
<Website>

<Date>

Dear Dr. / Ms. /Mr. _____ or To Whom It May Concern:

We are pleased to have the opportunity to better coordinate care of our mutual client by communicating with you about their recent visit.

This client has approved direct communication regarding our care plan and the provision of follow-up care as needed on an ongoing basis.

If you would like to further discuss coordination of care for this client, please contact us at the following phone number: XXX-XXX-XXXX and ask for our family planning provider.

The <Family Planning Health Center> providers are experts in sexual and reproductive health, and our services include the provision and management of all outpatient methods of contraception (except sterilizations) in a client-centered, safe and confidential setting.

We welcome referrals from you. You could send us a referral form with the patient or mail or fax it to us. For more information on how to refer your patients to our clinic, please call us at XXX-XXX-XXXX.

Thank you and we look forward to continuing to work with you and your patients,

(Name) Nurse Practitioner, <Family Planning Health Center>

Enclosed you will find pertinent health information from this client's visit.
Client's name:
Date of Birth:
Date of Visit:
Reason for Visit:
Diagnosis for visit:
Vital signs:
Smoking status:
Immunizations:
Lab tests and results:
Pap test and results:
Procedures:
Current medication list:
Current problem list:
Care plan with referrals and follow-up:
Self-management goal:

Third-Party Technical Assistance

LLC participants found bringing in outside technical assistance (TA) early in the process was extremely valuable. A TA provider can help your organization do an accurate and thorough assessment of strengths and weaknesses, determine what resources will be needed to meet the PCSP Standards, and provide adequate documentation. Additionally, a TA provider with expertise in practice transformation can help determine how best to make process and policy changes to maximize benefits of the transformation process, to not only achieve PCSP Recognition, but also to become a more effective and efficient health care provider.

Technical assistance or mentoring is available to NFPRHA members in several ways:

1. **NCQA:** As previously noted, the NCQA program manager assigned to your organization can be a valuable resource who can answer questions about the application, documentation, Standards and other issues, and can direct you to additional NCQA resources.
2. **NFPRHA:** In addition to this toolkit, NFPRHA staff is currently building internal expertise on NCQA Recognition Programs. As this knowledge builds, NFPRHA intends to offer support to members seeking recognition.
3. **Certified Content Experts:** NCQA offers a Content Expert Certification (CEC) program that certifies individuals as experts in PCMH.[14] Currently, there is no CEC program for PCSP. However, because there are similarities between PCMH and PCSP, a content expert in PCMH will understand many of the steps, processes, and transformation work required for PCSP. You can locate a CEC near you through the NCQA website.
4. **Peer to Peer Support:** A person or organization that has participated in PCSP transformation and documentation development can also be a source of external expertise. An informal mentoring relationship with a family planning organization that has already submitted a PCSP Recognition application may be valuable. NFPRHA can connect interested members with LLC participants.

Tool 15: TA Provider Selection Tool (A) (D) (T)

Developed by HMA Community Strategies, these questions can help your organization think through how and when to engage a TA provider and desired qualifications and skills to seek.

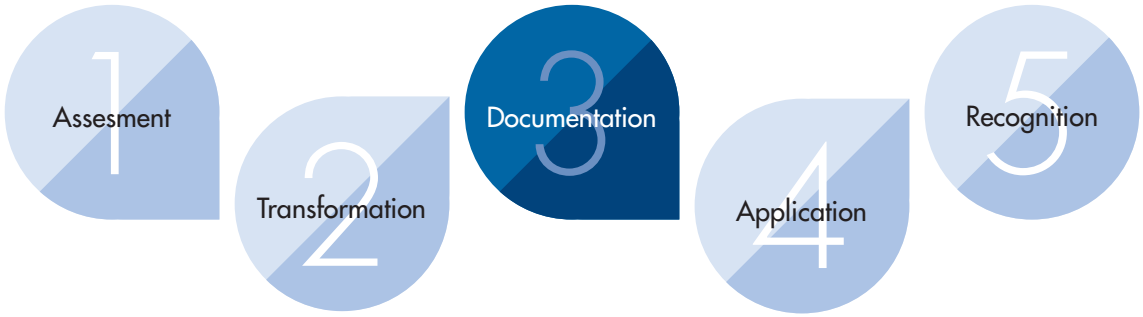
1. TA Provider Selection Tool
   - ☐ What do we think we might need help with?
   - ☐ Learning about what is required
   - ☐ Assessing whether we have the resources to move forward
   - ☐ Self-scoring and assessing our strengths
   - ☐ Managing the project
   - ☐ Practice transformation
   - ☐ Making IT changes
   - ☐ Writing new policies and protocols
   - ☐ Training staff on new policies
   - ☐ Specific standards
   - ☐ We don't know
2. How soon in the process do we need to find a TA provider?
   - ☐ We need immediate help
   - ☐ We will need help once we are ready to start practice transformation
   - ☐ We will need help once we are ready to start developing documentation
   - ☐ We will need help as we begin to submit our survey
   - ☐ We don't know
3. How much help do we think we will need?
   - ☐ Just a few hours
   - ☐ A few days
   - ☐ More than a few days
   - ☐ Ongoing, regular help on a weekly or daily basis
   - ☐ We don't know
4. Do we have funding to pay for technical assistance?
   - ☐ Yes
   - ☐ No
   - ☐ We don't know
5. What qualifications or expertise does your organization want its TA provider to have?
   - ☐ Clinical background
   - ☐ Experience with practice transformation
   - ☐ Experience with PCSP/PCMH
   - ☐ Experience with Title X/QFP
   - ☐ NCQA CEC
   - ☐ Project management expertise
   - ☐ IT expertise
   - ☐ Other
   - ☐ We don't know

If your organization answered "We don't know" to any of the questions above, it might be helpful to reach out to a TA provider to ask a few questions about what is available, or to an early adopter to ask how they used and paid for TA, and how the TA helped them.

If your organization is considering utilizing a TA provider, there are many factors to consider.

LLC Lessons Learned: Technical Assistance

- TA can be used at the start of the application process with a focus on the scoring of the organizational readiness for PCSP Recognition. The outside perspective is often critical and invaluable.
- Organizations can maximize TA investment by prioritizing needs. It may be possible to engage a provider for the most critical needs rather than the entire process.



Phase 3: Documentation

Although many Title X-funded organizations are already doing the work of a PCSP, determining how best to document this work can be a challenge. Because organizations operate differently, every application and transformation process are different. As a result, the process to document and meet each Standard and corresponding application materials should be unique to the organization. On one hand, this offers an organization the flexibility to develop an approach to the PCSP Recognition that best suits its infrastructure. However, there are no uniform documentation templates, and project staff must identify how to present evidence that reflects how an individual organization implements and tracks quality improvements. Developing these processes and making the subsequent system changes takes time.

For example, a health center may already offer same-day appointments, which helps meet PCSP Standard 2, but stating this availability is not enough. In order to meet the Standard, an applicant must submit documentation that demonstrates access to same-day appointments, e.g. a screenshot of dedicated time slots for same-day appointments in a patient management system. An organization that does not have adequate documentation in place would have to create or revise a process to capture the data, alter data collection mechanism (most commonly, the EHR), educate staff on the new policy, and have the process in place for the specified amount of time before collecting the documentation.

What is Prevalidation?

Prevalidation provides automatic credit when a technology solution completely meets a requirement. In other words, additional documentation is not required when meeting a Factor can be demonstrated through documentation that already occurs in an HIT system. The IT vendor must be pre-validated by NCQA and additional requirements apply. Visit NCQA.org for more information.

NCQA defines several types of documentation:

- **Documented process:** Written procedures, protocols, processes, and workflow forms; all processes must include the practice name and date of implementation;
- **Reports:** Aggregated data showing evidence. Reports must include time period in which data was collected. The length of time periods requested vary;
- **Records or files:** Patient files or registry entries documenting action taken; data from medical records. All of patients' protected health information (PHI) should be removed;
- **Materials:** Information for patients or clinicians, for example, clinical guidelines, self-management, and educational resources. These can include website and other electronic materials.

NCQA has developed a "Document Preparation Tips" should be reviewed before and during the documentation development process.

The tips cover:

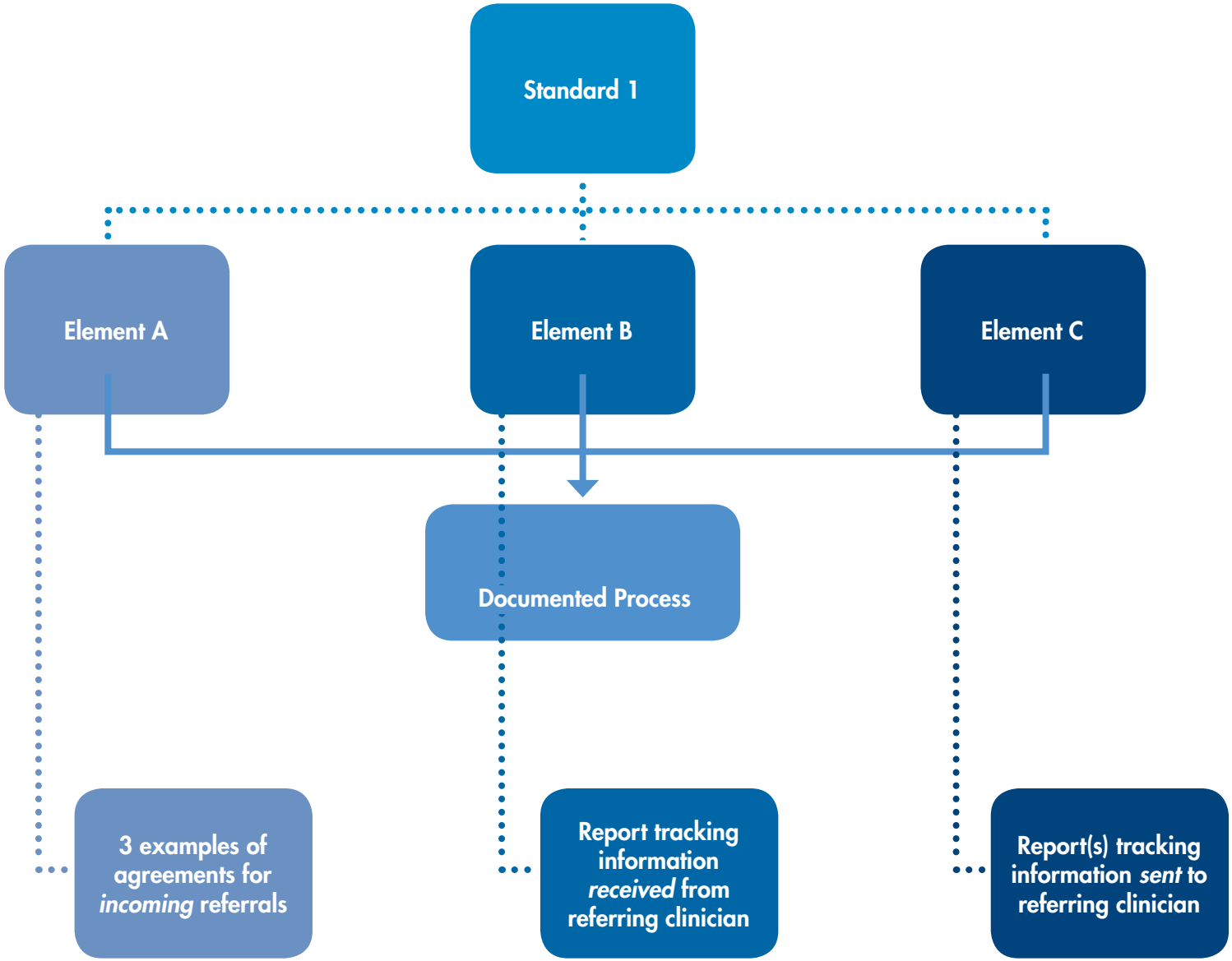
1. How to remove PHI from documents;
2. How to prepare documentation, including types of documents and examples;
3. Documentation time periods;
4. How to organize supporting documents; and
5. How to manage documents.

Maximize Documentation Efforts

It is important to note that one piece of documentation may attest for more than one Standard, Element, or Factor. If organizational processes, polices, or tracking mechanisms need to be developed or tweaked, consider how multiple requirements can be addressed in one document. For example, under Standard 1, Elements A, B, and C all require a written process. If a single process addresses the Factors in each of these Elements it can be uploaded once during the application process and used as evidence for each Element. When using one document to demonstrate more than requirement, it is critical to label what content pertains to which Element and Factor.

> "It is a learning process; as you move forward, you will get better at it."
>
> ~ Katrina Main-Dorskey, Clinical Quality Improvement NP, Maine Family Planning

Some Factors require more than one piece of evidence; many require a written process ***and*** reports to show the process is in effect. In order to earn points, Factors must be represented in both documents. This flow chart shows one way documentation could be organized for Standard 1.


Standard 1
Element A
Element B
Element C
Documented Process
3 examples of agreements for *incoming* referrals
Report tracking information *received* from referring clinician
Report(s) tracking information *sent* to referring clinician

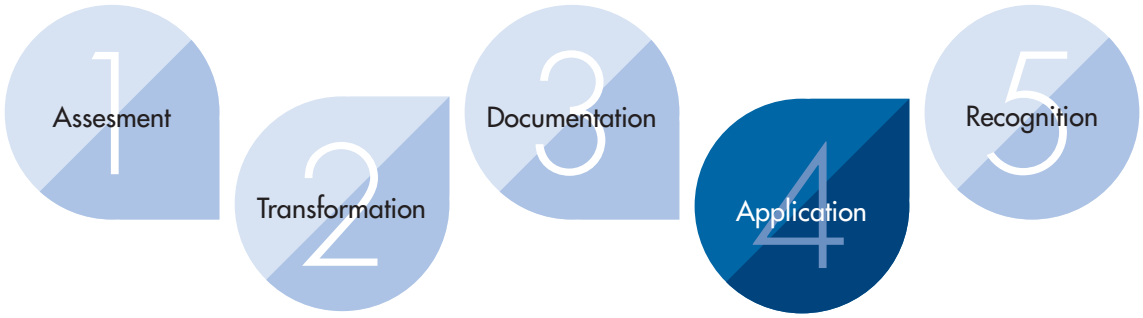
Tool 16: Documentation Check List (D)

This checklist, developed by HMA Community Strategies, can be printed, or used electronically, to check off the pieces of documentation that you have ready. **Please note that you must consult the NCQA PCSP Standards for very specific details about what the documentation needs to include.** This abbreviated checklist offers a high level overview of the documentation requirements, but the Standards should be consulted frequently for clarity on the finer details. Below is a portion of the checklist; the full document is available for download at nationalfamilyplanning.org.

	PCSP 1: Track and Coordinate Referrals					
	Element 1A - Referral Process and Agreements *Must Pass*					
	The practice has a written process for implementing and managing referrals with PCPs and other referring clinicans including:	(Check if Yes)				
1	Formal and Informal agreements with a subset of referring clinicians based on established criteria		Documented Process	AND		Example
2	Specified methods of communication with PCPs and referring clinician (if not PCP)		Documented Process	AND		Example
3	Specified method of communicating with the patient/family/caregiver about the specialist's plan of care		Documented Process	AND		Example
4	Specified co-management or transition strategy for selected patients		Documented Process	AND		Example
5	Confirmation of receipt and acceptance of referral with date and time of appointment		Documented Process	AND		Example
6	Specified information needed from referring clinician about patients		Documented Process	AND		Example
7	Specified information and timing of referral response to PCPs and referring clinicians (if not PCP)		Documented Process	AND		Example
8	Type and method of communication with the patient and family/caregiver about results and treatment		Documented Process	AND		Example
	Factors 1-8: Documented Process for staff					
	Factors 1-8: Three (not eight) examples of the agreements with practices demonstarting that the prrocess has been implemented.					
	Element 1B - Referral Content					
	The practice has a written process and monitors against it to ensure receipt of information needed in referrals from referring clinicians.	(Check if Yes)				
1	Clinical question(s) to be answered by the referral		Documented Process	AND		Report with 1 Month of Data
						Report with 1

LLC Lessons Learned: Documentation

- More is not necessarily better when it comes to documentation. Documentation that exceeds requirements can be burdensome to reviewers.
- The request for a written process is not limited to an official policy or procedure; flow charts, job aids, clinical forms, and similar materials are also acceptable forms of documentation of a written process.
- Use free, online software to capture screenshot for documentation, such as Jing.
- It is critical to have a system to organize and track documentation; the naming convention for files should reflect the Standards and Elements.
- Gathering, formatting, and organizing documentation is time consuming.
- Time periods for reports are essential and vary by Element.
- Highlight, text boxes, and arrows should be used to identify the specific areas of a document that demonstrate meeting a Factor; the process is easier if the designated staff member has needed technical skills.
- A single process, protocol, or report can be used to attest to multiple Standards, Elements, and Factors.
- Combining multiple materials into one document can ease the process for application reviewers.
- Not having a specific template to follow can be frustrating, but documentation should reflect the unique practices of an organization.



Phase 4: Application

1. Order the Free Online Application

Once your organization has decided to pursue PCSP Recognition, there are some important steps to take, including notifying NCQA of your interest.

To establish an online account, order NCQA's free, online application. This application collects organizational and clinician information and requires signatures for various program agreements. A primary contact must be designated to create an online account for your organization with a user name and password. One online account can house many individual site applications.

The online account also contains a resource library and is where an organization would initiate a multi-site application approval. As previously noted, NCQA offers a streamlined recognition process for organizations with three or more practice sites. Organizations must obtain NCQA approval to pursue a multiple-site application. Once approved, use the "Multi-site/New Multi-specialty Application or the Multi-site Manager" tab on the application to complete your application.

A request for an Add-On survey is also done through the online application (more information on the Add-On survey is in Phase 5).

Whether pursuing single site or multi-site eligibility, within 1 to 5 days of submitting the online application, an NCQA manager will schedule a time to discuss eligibility.

2. Buy NCQA ISS Survey Tool

Once your practice has transformed to meet the Standards and documentation has been collected and organized, purchase the Interactive Survey System (ISS) Survey Tool. This is NCQA's interactive software required to demonstrate how an organization meets the PCSP Standards. A free, recorded training on how to use the software is available and it is recommended that it be taken at least **30 days** before the ISS Survey Tool is submitted.

Organizations use the web-based ISS Survey Tool to upload the documentation, including reports, policies, and communication materials, required to show a site's medical home/specialty practice features. Documentation can be uploaded and saved over time. Be sure to respond to every Factor with a yes, no, or N/A. The N/A response can only be used in very specific instances and will be scored as a yes if (and only if) an **explanation is provided in the appropriate text box**.

The ISS Survey Tool also contains several mechanisms for applicants to provide narrative context for reviewers. The **Organizational Background** tab allows you to share an overview of your health center. The **Support Text/Notes** function gives an organization the opportunity to clarify the intention of documentation or processes.

The ISS Survey Tool costs $80. Sites that meet multi-site eligibility requirements must purchase an ISS Survey Tool for each practice site, plus an additional ISS Survey Tool for the Multi-Site Group Survey. The survey tool can be purchased through NCQA.org.

3. Submit Online Application

Next, your organization must submit the Online Application, which should be submitted at least **five business days** before the ISS Survey Tool to ensure enough time to link the two tools.

Since recognition is at the practice-site level, a separate application with clinician data should be created for each individual site. Again, one online account can be used to submit multiple individual site applications.

Utilize Support Text/ Notes Function

Explanation text boxes can be used to explain various aspects of your application. For example, PCSP 6, Element C requires practices to set three quality measures. The measures don't have to be HEDIS or NQF approved, but they do need to relate to the specialty. Family planning providers may select BMI, because it influences birth control method selection. However, a reviewer may not understand how this measure is related to family planning. Describing this connection is a great example of how an explanation text box can be used.

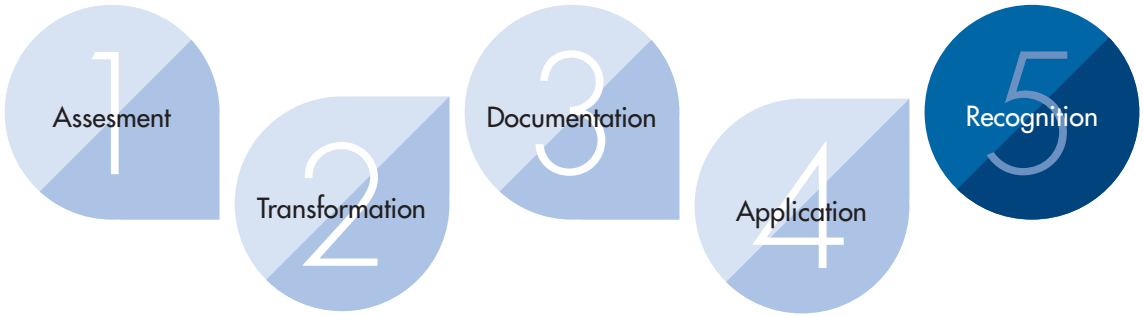
4. Submit the ISS Survey

Your organization will pay the application fee when it is ready to submit the survey tool and related documentation. The fee is based on the number of sites and the number of clinicians at each site and can range from $550 to more than $6,600.

While none of the LLC participants have found financial support for the application fee, some other early adopters have found sponsoring organizations, such as partner health plans, that have paid some or all of this fee for them. More information on sponsor organizations can be found at NCQA.org.

LLC Lesson Learned: Application

- It is useful to use the Support Text/Notes option to add context to your processes and documentation.
- Clinicians can be added and deleted to the application throughout the recognition process.
- Uploading documentation is time-consuming. Be sure to start the process in enough time to meet any deadlines.
- The Corporate ISS Survey Tool of a multi-site application should not be submitted until individual sites are close to meeting the Standards.



Phase 5: Recognition

Once a survey tool is submitted, NCQA estimates that materials will be reviewed and scored in 30-60 days. Notification of results is sent via e-mail. During this time, it may be helpful to begin planning a communications strategy to publicize your achievement.

If you achieve recognition, first take some time to celebrate. It is important that efforts of the team are recognized and acknowledged, and the significance of the recognition is celebrated.

Next, your organization should begin to publicize its achievement – to other providers, insurance plans, and current and potential future patients. NCQA provides advertising guidelines, graphics, and sample press releases and other materials to help support your communications efforts. These materials can be accessed on NCQA's website and a media toolkit will be mailed with your certification of recognition (approximately three weeks after notification of recognition is received). In addition, practices that receive recognition are listed on NCQA's online, searchable Recognition Directory.

Tool 17: PCSP Recognition Communications Checklist

From staff to payers, various audiences should be informed of your PCSP Recognition. This checklist can help organizations identify, plan, and assign communication needs once recognition is received.

PCSP Recognition Communications Checklist				
Audience	Staff Lead	Method/Platform	Tasks	Timeline
Staff		• Staff meeting • E-communication	• Create handout/email with PCSP talking points for staff	
Board of Directors		• Board meeting • E-communication	• Include in agenda	
Current Patients		• Branded collateral such as posters, brochures, and postcards • Email message from health center • Website • Social media	• Add PCSP logo to website, brochures • Develop waiting room materials • Develop relevant social media content such as tweets, Facebook posts and share graphics • For website: Feature new recognition on homepage of center's website.	
General Community		• Press release to local newspaper • Community outreach events • Social media	• Customize sample press release • E-mail local and trade news reporters • Submit local letter to the editor or op-ed • Place advertisement in local paper	
Payers		• Letter	• Write and send letter to all contracted payers	
Partner or Community-based Organization		• E-mail	• Write and send e-mail to appropriate agencies	

Tool 18: Sample Letter to Third-Party Payers

One highly anticipated benefit of PCSP is the adoption of local, state, and public/private payer PCSP initiatives that offer payment incentives to participating practices that achieve recognition. Such incentive programs exist across the country for PCMH. As a newer program, fewer PCSP incentives are established, but similar uptake is expected. This NFPRHA-developed sample letter informs a third-party payer of a health center's recognition and encourages it to include PCSP in its incentive program.

[DATE]

[THIRD-PARTY PAYER]
[ADDRESS]

RE: Patient-Centered Specialty Practice Recognition

Dear [THIRD-PARTY PAYER]:

[AGENCY NAME] serves nearly [XXXXX] patients annually by providing a wide range of quality reproductive health care services at our [XX] health centers. We have served women and men of all ages since [APPROPRIATE TIME FRAME], and our services are provided by licensed health care professionals, including licensed medical doctors, nurse practitioners, and pharmacists.

As of [APPROPRIATE DATE], [AGENCY NAME] has been awarded recognition by the National Committee for Quality Assurance (NCQA) Patient-Centered Specialty Practice (PCSP) Program. NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS®, the performance measurement tool used by more than 90 percent of the nation's health plans.

Practices that become recognized under PSCP Recognition have demonstrated commitment to patient-centered care and clinical quality through: streamlined referral processes and care coordination with referring clinicians, timely patient and caregiver-focused care management, and continuous clinical quality improvement.

Earning NCQA PCSP Recognition shows consumers, payers, and government agencies that the practice has undergone a rigorous review of its capabilities and is committed to sharing information and coordinating care. Recognition also signals to primary care practices that the specialty practice is ready to be an effective partner in caring for patients.

We share your commitment to improve the health outcomes of your members -- NCQA PCSP Recognition demonstrates this commitment. What is more, the designation translates into tangible improvements in your metrics. Specifically, including [AGENCY NAME] in your network will improve your rates of [XXXX]. As such, we encourage [PAYER NAME] to consider including NCQA PCSP Recognition as a component of incentive programs you have that reward high quality care.

We look forward to hearing from you regarding your decision to offer a program incentive for NCQA PCSP Recognition. Please don't hesitate to contact me with any questions.

Regards,
[CEO NAME]
President and CEO
[AGENCY NAME]

Reconsideration Requests and Add-On Surveys

A practice must receive a minimum of 25 points to achieve recognition. Any organization that does not agree with the scoring of its application can submit a "Reconsideration Request." To request reconsideration, your organization must submit an e-mail to your NCQA manager within 30 days of the recognition decision. Practices can outline the disputed Elements and Factors and provide a rationale for the disagreement, but no additional documentation can be submitted with the Reconsideration Request. A new team of reviewers will be assigned to the application and all decisions are final. The cost for reconsideration is the lesser of $500 or the cost of each Add-On Survey for each site.

For a discounted application fee (50% of full fee), a practice that did not pass or would like to increase its level of recognition can submit an Add-On Survey. This process allows a health center to change responses to Elements that scored below 100% and provide new documentation. Add-On Surveys may be submitted anytime within the current Recognition period or within 12 months of a non-passing decision. Results for a reconsideration or Add-On Survey will be given within 30-60 calendar days.

Maintain Your Recognition

Recognition lasts three years, but the renewal process for your organization should start at least six months before expiration. Requirements for renewal differ between a multi-site and single site and the level of recognition. Levels 2 and 3 have the option of a streamlined renewal, permitting reduced documentation requirements. Practices that satisfactorily demonstrated basic specialty practice transformation can focus on more advanced aspects of redesign for their renewal applications. Renewal for Level 1 requires a full survey. A full description of requirements is available at NCQA.org.

Conclusion

NCQA recognition is an exciting opportunity that allows family planning providers to demonstrate coordinated care, improve patient access, and ensure increased shared decision-making with patients. The toolkit breaks the recognition process into five sections: Assessment, Transformation, Documentation, Application, and Recognition. Tools presented in the document and available online are intended to help organizations determine if PCSP is right for them and, if so, provide support throughout the recognition process.

LLC participants report that the recognition process resulted in stronger and more knowledgeable care teams. Taking a collaborative approach with strong leadership that engages various levels of staff to design a strategic and deliberate recognition process can make the process less challenging. While long term benefits are still being analyzed, early adopters reported immediate improvements in patient-centeredness, team-based collaboration, and operational efficiency. PCSP is one pathway for a health center to improve patient experience and outcomes, streamline clinical processes and procedures, and boost overall sustainability.

Endnotes

1 Growth of Recognized Medical Homes Accessed July 22, 2015. www.ncqa.org.

2 "NCQA Programs Recognition Practices PCMH Evidence." NCQA Programs Recognition Practices PCMH Evidence. Accessed July 13, 2015. http://www.ncqa.org/Programs/Recognition/Practices/PCMHEvidence.aspx.

3 Raskas, R. S., L. M. Latts, J. R. Hummel, D. Wenners, H. Levine, and S. R. Nussbaum. "Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality." Health Affairs, 2012, 2002-009.

4 Advancing Primary Care Delivery: Practical, Proven, and Scalable Approaches.: UnitedHealth Center for Health Reform & Modernization, September 2014. Accessed July 13, 2015. http://www.unitedhealthgroup.com/~/media/UHG/PDF/2014/UNH-Primary-Care-Report-Advancing-Primary-Care-Delivery.ashx

5 Edwards, S. T., A. Bitton, J. Hong, and B. E. Landon. "Patient-Centered Medical Home Initiatives Expanded In 2009-13: Providers, Patients, And Payment Incentives Increased." Health Affairs, 2014, 1823-831.

6 Ibid.

7 Patient Centered Specialty Practice Recognition. Washington, D.C: National Committee of Quality Assurance, 2013. Accessed July 13, 2015. http://www.ncqa.org/Portals/0/Newsroom/2013/PCSP%20Launch/PCSPR%202013%20White%20Paper%203.26.13%20formatted.pdf

8 Centers for Disease Control and Prevention. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs—United States, 2014. MMWR 2014;63(Suppl; April 25, 2014.:1-29.

9 Edwards, S. T., A. Bitton, J. Hong, and B. E. Landon. "Patient-Centered Medical Home Initiatives Expanded In 2009-13: Providers, Patients, And Payment Incentives Increased." Health Affairs, 2014, 1823-831.

10 The number of months that a process must be in place is dependent upon NCQA's requirement for the amount of data that must be collected. For PCSP Recognition, some policies require only one month of data while others require three months of data.

11 45 C.F.R. § 164.522(a)(1..

12 For more information about Title X and confidentiality see: Abigail English, Robin Summers, Julie Lewis, and Clare Coleman, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015.. Available at http://www.confidentialandcovered.com/research-and-findings#Publications.

13 42 C.F.R. § 59.11.

14 See the following website for more information about the CEC program: http://www.ncqa.org/EducationEvents/SeminarsandWebinars/PCMHContentExpertCertification.aspx

Appendix: Example Documentation

In order to receive PCSP Recognition, appropriate documentation must be submitted to demonstrate practices are meeting the PCSP 2013 Standards and Guidelines (Standards). The scoring mechanism is tied to Factors within each Element and points are earned when documentation accurately attests that the work for a Factor is being accomplished. Some Factors necessitate more than one type of documentation. In some cases, an organization may need to submit more evidence than is mandated to clearly demonstrate a Factor has been met. Detailed explanation regarding specific documentation requirements can be found in the Standards.

This appendix provides the Standards, including the related documentation requirements and scoring, for all five must-pass Elements, because they are so critical to earning recognition. A few non must-pass Elements that may pose a challenge to family planning and sexual health providers are also included. In addition, examples of documentation from LLC participants were adapted. A description and additional context is given for each example.

Because every organization differs in its policies and procedures, it is important to note that these are merely examples to guide organizations in thinking through their own documentation. It is expected that each organization develops its own documents to accurately reflect how it does its own work.

An example may or may not reflect appropriate documentation for every Factor, as an organization may determine that meeting a certain Factor is not within its capacity. In each of the examples provided below, notations are provided to highlight where in the example particular Factors are demonstrated. Similar notations should be included in submitted documentation to help reviewers easily identify necessary content.

Standard	**Must Pass Elements**	**Examples**
1 Track and Coordinate Referrals	1A Referral Process and Agreements	1, 2
	1B Referral Content	3, 4,
	1C Referral Response	5, 6
2 Provide Access and Communication	2E The Practice Team	7, 8, 9, 10, 11, 12
4 Plan and Manage Care	4B Medication Management	13, 14, 15, 16
6 Measure and Improve Performance	6C Implement and Demonstrate Continuous Quality Improvement	17

Throughout the document, symbols are used to indicate which Standard, Elements, and Factors are represented in each example. For instance, the following image indicates that evidence for Standard 1, Element A, Factors 1, 3, 5 can be found in the sample documentation.

Standard 1

Element A

Factors 1, 2, 3...

PCSP Standard 1: Track and Coordinate Referrals: Referral Process and Agreements

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

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

Factors

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.

Documentation Requirements:

Factors 1–8: For each Factor, the practice provides a:

- Documented process for staff, ***and***
- Three examples of the agreements with practices demonstrating that the process has been implemented

Scoring: A health center must meet 2–3 Factors to pass.

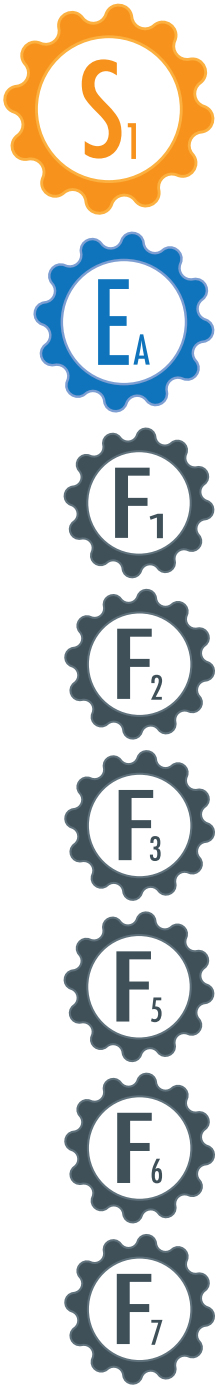
EXAMPLE 1: SAMPLE DOCUMENTED PROCESS, REFERRAL POLICY

Documentation requirements for PCSP Standard 1, Element A include a documented process for staff. All documented processes must include a date of implementation or revision and must be in place for at least three months prior to submitting the ISS Survey Tool.

Documentation of a referral process for PCSP 1A should include the following:

- the practice name;
- physician(s) or clinician(s) name(s);
- date the policy was created;
- the description of the policy;
- the purpose of the policy;
- description of the procedure;
  - including referral method, criteria, steps, and staff responsible
- any barriers; and
- a reporting process.

In addition, a process should address as many Factors as possible to maximize points. If a single process addresses multiple Standards, Elements, and/or Factors, it is possible to submit it once. However, it should contain notations to ensure reviewers can easily identify the content that relates to specific Standard, Element, and Factor.



<Practice Name>

Clinical Section

REFERRAL PROCESS (Incoming Referrals)

Purpose:

To ensure that care is coordinated efficiently and effectively for all patients referred from primary care provider to <practice name>.

Procedure:

RESPONSIBLE PARTY	ACTION
<Provider Name> **[PCSP 1A: FACTOR 6]**	• Referring <primary care practice> clinician indicates reason for the referral and where the patient is being referred. This referral will contain the following information which is also documented in the medical record: ▸ Name and contact information of the referring PCP provider ▸ Reason for referral ▸ Patient Demographics ▸ Name and practice site for the referral (with contact information) ▸ Pertinent clinical information including lab tests Information to report back to the requesting provider • Discuss need and considerations with PCP/referring physician if applicable (as noted in referral contract) or to the preferred list of providers that have agreed to accept referral, and to return pertinent medical information to assist in the patients' care. [PCSP 1A: FACTOR 1] • Initiate referral in EMR (eCW) and prioritize urgency indicating the reason for the urgency. • Assign team member to communicate information pertinent to the reason for referral and/or relevant for patient care coordination with the PCP or referring clinician. Communications should be done via secured email or telephone calls. [PCSP 1A: FACTOR 2] • Discuss the need for the referral with the patient during the visit assuring that they understand the importance of the referral

RESPONSIBLE PARTY	ACTION
Clerk or Nurse	• The <FP Organization> will communicate test results and treatment and management plans to the patient or caregiver during the patient visit. Documentation of discussion should be included in EHR progress notes. Written information regarding birth control method will be provided when applicable. [PCSP 1A: FACTOR 3] • Assigned <FP Organization> staff is to confirm receipt and acceptance of referral within 24 hours for urgent referrals and within five business days for non-urgent referrals. Communication should include date and time of patient's appointment. [PCSP 1A: FACTOR 5] • Scan returned referral consult forms in the patient medical record after they have been reviewed by the Family Planning medical provider.
CD/Nurse/Designee	• Review referral database weekly to assure all referrals have been followed up appropriately. • Family planning organization will send a referral summary to the PCP or referring clinician within two weeks of patient being seen. The summary will include patient demographics and information requested by referring provider. [PCSP 1A: FACTOR 7]

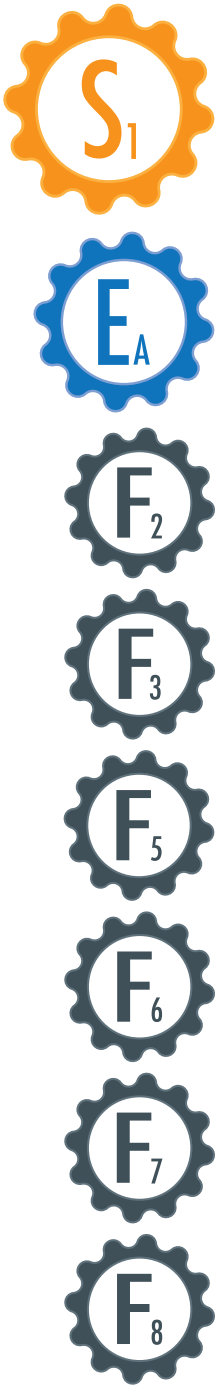
Effective 8/1/2014

Sample adapted from MIC Women's Health Services.

EXAMPLE 2: SAMPLE REFERRAL AGREEMENT

PCSP Standard1, Element A also requires **three** examples of agreements with practices demonstrating that the process has been implemented. These agreements help support the process by outlining what information should be received with an incoming referral, the process for sharing information with a referring clinician, and how this communication will occur. It is critical that the Factors outlined in the process also be demonstrated in the referral agreements.

Title X-funded providers should also ensure agreements include guidelines for communication regarding services that the patient may not want to share with their PCP or other provider. In other words, as a communication process is defined with a referring clinician, it is important to inform the provider that information regarding services deemed by the patient to be confidential may not be shared upon request. Refer to the Title X Program Requirements, Section 10 Confidentiality.



Family Planning Organization Logo

Referring Partner Logo

Referral Agreement

Between <Family Planning Organization> and <Primary Care Provider>

<Family Planning Organization> agrees to collaborate in the provision of comprehensive services to women, men, and their families residing in the communities we serve.

<Family Planning Organization> provides comprehensive reproductive health services. Patients can access through this provider (their own physician, nurse practitioner, or midwife) prenatal care, family planning services: birth control methods including IUD and Nexplanon insertions, GYN services, STI screening and treatment, HIV counseling, and testing, walk-in pregnancy testing, and referrals for specialty services at the partner hospital. Patients have access to a social worker as needed and can receive short-term mental health counseling. Males are seen for STI screening and treatment and HIV counseling and testing. Related health education is available for the patients and the surrounding community. <Primary Care Provider> will refer patients to <Family Planning Organization> for these services.

In the collaboration with <Family Planning Organization>;<PCP> will provide primary outpatient medical care including, but not limited to, care for hypertension, diabetes, obesity as well as other specialty referrals as required for the patients' care.

Coordination and Communication with <Family Planning Organization> and <PCP>

The entity providing services will obtain signed consent from the patient or caregiver to coordinate care and share relevant information between <PCP> and <Family Planning Organization>. <Family Planning Organization> will only share information about patients who have given signed consent to do so. We both agree to same-day access for urgent referrals and to have a medical provider available on site for consults as needed. We each will utilize our agencies' consult form to request services between the two offices and agree to send the form back with the requested information, confirmation of receipt and acceptance of referral, and date and time of patient appointment [PCSP 1A: Factor 2]; additional information required for patient care coordination will be communicated via secure email or telephone [PCSP 1A: Factor 5]. Consult forms should include patient demographics, reason for referral, urgency of referral, and clinical information [PCSP 1A: Factor 6]. The provider of services will send a referral summary to the referring agency within two weeks of the patient appointment; the summary will include information, including but not limited to: test results, selection of birth control method, and clinical information, that is pertinent to the provision of sexual and reproductive health services [PCSP 1A: Factor 7].

Communication and Coordination with Patient/Caregivers

Test results, treatment options, and care plans will be discussed with patients/caregivers by the provider of services during the appointment or within 48 hours of receipt of lab results. Communication with patients/caregivers is to be documented in the medical record; any changes in the care plan related to sexual and reproductive health will be communicated to the patient/caregiver by <FP Organization>. [PCSP 1A: FACTOR 3,8]

_____

Name

_____ _____

Signature Date

_____

Family Planning Organization

_____

Name

_____ _____

Signature Date

_____

Primary Care Provider/Referring Clinician

Sample adapted from MIC Women's Health Services.

PCSP Standard 1: Track and Coordinate Referrals: Referral Process and Agreements

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

ELEMENT B: REFERRAL CONTENT

The practice has a written process and monitors against it to ensure receipt of information needed in referrals from referring clinicians:

Factors

1. Clinical question(s) to be answered by the referral.
2. Type of referral.
3. Urgency of referral.
4. Patient demographics.
5. Clinical information.
6. Current primary practice care plan, treatment, test results and procedures.
7. Communication with patient/family/caregiver.

Documentation Requirements:

Factors 1–7: For each Factor, the practice has a:

- Documented process for staff to follow in communicating what is expected in the referral from primary care or referring clinician, ***and***
- Report(s) demonstrating information provided by referring clinicians based on at least one month of data or data from 30 new referrals. This implies that the specialist has a tracking system for the information received from referring clinicians and can generate reports showing the information that has been successfully received versus data that should have been included but was not part of the referral.

Scoring: PCSP 1B is not a must-pass Element, but due to the high percentage of self-referred patients, the documentation requirements may pose a challenge to family planning providers.

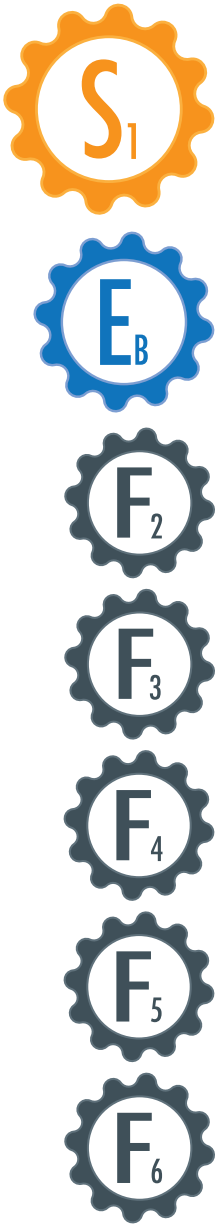
EXAMPLE 3: SAMPLE DOCUMENTED PROCESS, REFERRAL FORM

Documentation for PCSP Standard 1, Element B includes a documented process that outlines the information staff should obtain from a referring provider and tracks that the information is received. In other words, the intent of Element 1B is to ensure specialty practices inform providers who refer patients to the specialty practice what information is needed with a referral, and the specialty practice monitors that this information is received.

A thorough referral form could meet the criteria of a documented process; particularly if it is included as an appendix to a referral agreement and provides guidance for staff. Additional information regarding how information received with incoming referrals is tracked is needed to bolster this example.

A written policy that specifies what content an incoming referral should contain and a procedure for tracking information received could also meet the documentation requirements of Standard 1, Element B.

Again, the more Factors that are addressed in a piece of documentation, the more points will be awarded.



Family Planning Practice Name

Consultation form for Consulting Provider (Fax back to xxx-xxx-xxxx)

Patient First Name_____ Patient Last Name_____

DOB: _____ Weight: _____ Primary Contact #_____

Primary language: _____

Insurance provider: _____ [PSCP 1B: Factor 4]

DATE	
Referring Clinician	
Type of Referral (consult, testing, follow-up, consult and treatment)	[PCSP 1B: Factor 2]
Urgency (STAT or same day; Urgent (<48 hours); Routine (>48 hours)	[PCSP 1B: Factor 3]
Reason for Consult:	[PCSP 1B: Factor 2]
History of present Illness:	[PCSP 1B: Factor 5]
Medications:	[PCSP 1B: Factor 5]
Pertinent medical/ surgery history:	[PCSP 1B: Factor 5]
Allergies:	[PCSP 1B: Factor 5]
Diagnosis (Pertinent findings on exam):	
Pertinent Lab findings:	
Impression:	
Test results sent to specialist • **Test One** • **Test Two** • **Etc...**	[PCSP 1B: Factor 6] ☐ Sent ☐ Sent ☐ Sent
Recommendations:	[PCSP 1B: Factor 6]
Follow-Up Appointments:	
Notes:	

PLEASE FAX THIS TO <FAMILY PLANNING PRACTICE> WITH PATIENT REFERRAL

<FAMILY PLANNING PRACTICE> Tel: XXX-XXX-XXXX Fax: XXX-XXX-XXXX

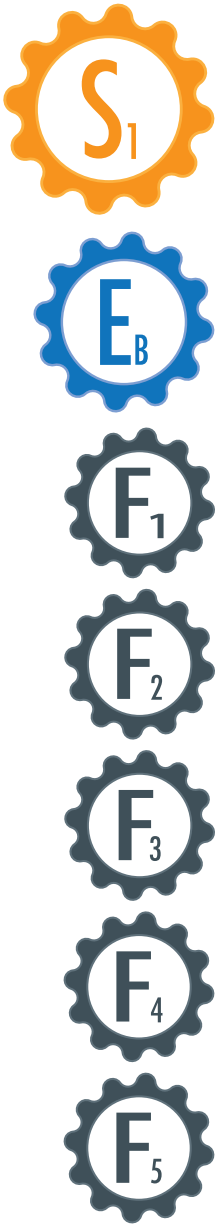
Sample adapted from MIC Women's Health Services

EXAMPLE 4: SAMPLE REPORT, REFERRAL CONTENT

To verify that specialty practices are monitoring incoming referral content, PCSP Standard 1, Element B also requires a report(s) showing what information has been provided by referring clinicians. The report should reflect at least one month of data or data from 30 new referrals. The report should illustrate that the specialist has a system to track information received from referring clinicians that indicates whether requested information was successfully received or missing from an incoming referral.

Factors must be reflected in ***both*** the process and the referral content report.

This is also an example of how a report can attest to more than one Element, as this report reflects evidence of Factors for Standard 1, Elements B and C.



<Family Planning Organization>

REPORT FILTERS:

CENTER: <Health Center Name>

REFERRAL DATE RANGE: 2/1/2014 through 1/19/2015

REFERRAL TYPE: Incoming

Referral ID	Referral Type	Accnt No	Pt Name	DOB	Ref Date	Confirm Receipt Sent	Gender	Status	Specialty	Facility From:	Facility To:	Urgency	Primary Lang
	[PCSP 1B Factor 2]			[PCSP 1B Factor 4]		[PCSP 1C: Factor 7]	[PCSP 1B Factor 4]					[PCSP 1B Factor 3]	[PCSP 1B Factor 4]
Referral 1	Incoming	*******	*******	**/**/****	12/30 2014	12/31 2014	Female	open	Nurse midwife	<PCP/ Referring Clinician>	<FP Org>	High	English
Insurance:	<Name of health plan>												
Reason:	OBGYN services [PCSP 1B: Factor 1], [PCSP 1C: Factor 2]												
Notes:													
Assigned:	<Clinician Name>												
Allergies	NKDA [PCSP 1B Factor 5]												
Diagnosis:	V22.1 SUPERVIS OTH NORMAL PREG [PCSP 1C: Factor 3]												
Tests Results	Positive pregnancy test							Date sent to PCP/RC: [PCSP 1C Factor 4]				1/10/15	
Referral 2	Incoming	*******	*******	**/**/****	10/7 2014	10/8/ 2014	Female	closed	Nurse midwife	<PCP/ Referring Clinician>	<FP Org>	Medium	Chinese-Mandarin
Insurance:	<Name of health plan>												
Reason:	36 Y.O female with Reactive FTA-ABS . PLEASE EVALUATE AND TREAT IF NEEDED. [PCSP 1B: Factor 1] [PCSP 1C: Factor 2]												
Notes:	<Clinician Name> 10/07/2014 10:33:31 AM > pt referred from pcp for further evaluation of syphilis. please asess. labs for rpr/fta-abs scanned into pt												
Assigned To:	<Clinician Name>												
Allergies:	[PCSP 1B Factor 5]												
Diagnosis:	097.9 Syphilis NOS [PCSP 1C: Factor 3]												
Tests Results								Date sent to PCP/RC: [PCSP 1C Factor 4]				10/15/14	

Sample adapted from MIC Women's Health Services.

PCSP Standard 1: Track and Coordinate Referrals: Referral Process and Agreements

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

ELEMENT C: REFERRAL RESPONSE

The practice has a written process and monitors against it to ensure a timely response to PCPs and referring clinicians that includes:

Factors

1. Tracking system for confirming receipt of the referral and sending date and time of the appointment to the referring clinician.
2. Answer(s) to clinical question(s) in referral.
3. Diagnosis.
4. Procedures and test results.
5. Recommended specialist's plan of care, care management, patient education, secondary referrals.
6. Follow-up needed with specialist including further coordination.
7. Tracking system for monitoring timeliness of referral response.
8. Providing an electronic summary of care record to another provider for more than 50 percent of referrals.++/+

++/+ Stage 1 Menu/Stage 2 Core Meaningful Use Requirement (To the extent possible, PCSP Standards are aligned with CMS Meaningful Use (MU) requirements. Individual Factors are identified in the Standards as either Menu or Core MU with ++ or + symbols)

Documentation Requirements:

Factors 1–7: The practice has a documented process for staff to follow for providing a timely response to the referring clinician and patients, ***and***

- Factor 1: The practice has a report from a tracking system based on at least 1 month of data or data from 30 new referrals showing when the referring clinician was notified of receipt of the referral request and the date and time of the patient's appointment.
- Factors 2–6: The practice has a report from a tracking system based on at least 1 month of data or data from 30 new referrals demonstrating information provided to primary care or referring clinician. Factor 7: The practice has a report from a tracking system based on at least 1 month of data or data from30 new referrals showing when the specialist sent the referral response to the referring clinician in relation to when the referral was received by the specialist.
- Factor 8: The practice provides a report from the electronic system with a calculated percentage based on a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent three-month period for the calculation.

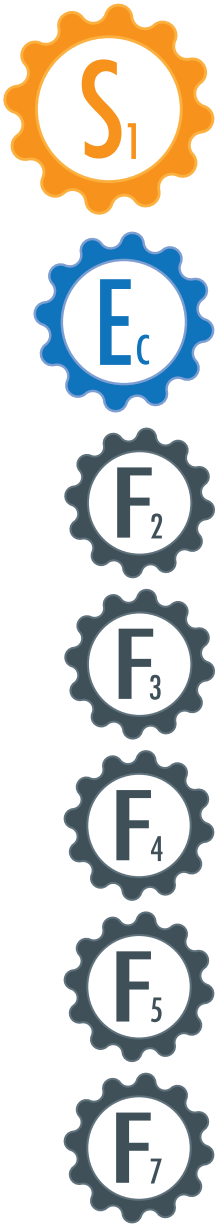
The practice may use the following methodology to calculate the percentage.

- Denominator = Number of transitions back to referring clinician/primary care.
- Numerator = Number of transitions back to referring clinician/primary care in the denominator where a summary of care record was provided.

Scoring: A health center must meet three Factors to pass.

EXAMPLE 5: SAMPLE DOCUMENTED PROCESS, INCOMING REFERRAL RESPONSE

Coordinating care is an essential component of the Standards and as a result, a health center must demonstrate that it communicates regularly with referring providers. To comply with Standard 1, Element C, a health center must have a referral process that includes guidance on how the specialty practice communicates with referring providers.



<Family Planning Organization>

Clinical Section

REFERRAL PROCESS (Incoming Referrals)

Purpose: To ensure that care is coordinated efficiently and effectively for all patients referred to <Family Planning Organization>.

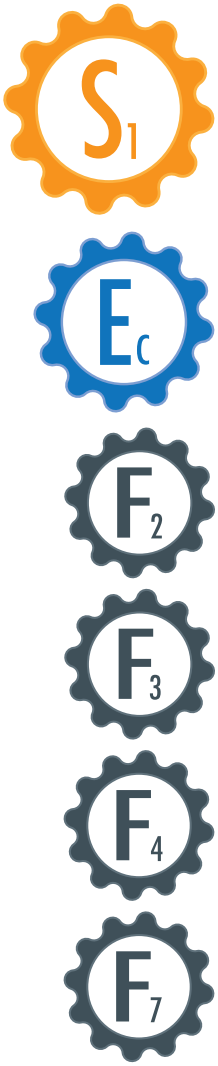
Procedure:

RESPONSIBLE PARTY	ACTION
Patient Self Referrals:	
Clerk	• Confirm that the patient's PCP contact information is in the medical record. • Assure that consent for treatment is signed and in the record (includes consent to communicate with other providers).
Provider or Designee	• At every visit, ask patients if they have seen another specialist and document in EHR if they have. • Discuss the referral process with the patient reminding them that you will communicate with and send pertinent medical information to their PCP or other referring provider. Response to the referring provider: • Documentation via a referral form that was received or a summary of findings to be sent back to the referring provider will include: the answer to the clinical question or the patient's complaint if they are self-referral [PCSP 1C: Factor 2], the diagnosis [PCSP 1C: Factor 3], procedures and test results done to address the reason for the referral [PCSP 1C: Factor 4], and the plan of care that has been discussed with the patient [PCSP 1C: Factor 5]. The summary should also address co-management of the patient if that is required. • All documentation will be in the patient's medical record in the treatment and referral sections of the EHR. [PCSP 1C: Factor 7] • Assign the referral to the nurse after the patient is seen. • Nurse- Print visit summary and fax to referring provider within seven days of patient visit; document that this was done in the referral section of EHR: add documentation to structured data, as well as add notes to 'Comments' section. [PCSP 1C: Factor 7] ▸ Time stamp that fax was sent in structured data • Explain and confirm understanding of the plan of care with patient.
Hospital Coordination	
	• Request discharge papers for all existing patients that visit the ER or hospital facilities from the patient or the facility. • Document such request in telephone encounter. • Comply with and respond to all hospital or ER requests for patient information, with patient consent or in the case that patient cannot give consent with the consent of the authorized representative. • Scan HIPAA form into patient documents. • Document that information was sent in telephone encounter.

Implemented July 7, 2014

Sample adapted from MIC Women's Health Services.

EXAMPLE 6: SAMPLE REPORT, REFERRAL RESPONSE DOCUMENTATION



In accordance with PCSP Standard 1, Element C, health centers should also have a system in place to monitor its communication with referring providers. In addition to the referral process, the specialty practice must also submit a report that documents the implementation of the referral response processes.

The data report for Factors1–7 should include at least one month of data or information from 30 new referrals; the report for Factor 8 should be based on twelve months of data and include a denominator and numerator.

This is the same report that was used to show support for Standard 1, Element B. In the application process this document would only need to be uploaded once.

Referral ID	Referral Type	Accnt No	Pt Name	DOB	Ref Date	Confirm Receipt Sent	Gender	Status	Specialty	Facility From:	Facility To:	Urgency	Primary Lang
	[PCSP 1B Factor 2]			[PCSP 1B Factor 4]		[PCSP 1C: Factor 7]	[PCSP 1B Factor 4]					[PCSP 1B Factor 3]	[PCSP 1B Factor 4]
Referral 1	Incoming	*******	*******	**/**/****	12/30 2014	12/31 2014	Female	open	Nurse midwife	<PCP/ Referring Clinician>	<FP Org>	High	English
Insurance:	<Name of health plan>												
Reason:	OBGYN services [PCSP 1B: Factor 1], [PCSP 1C: Factor 2]												
Notes:													
Assigned:	<Clinician Name>												
Allergies	NKDA [PCSP 1B Factor 5]												
Diagnosis:	V22.1 SUPERVIS OTH NORMAL PREG [PCSP 1C: Factor 3]												
Tests Results	Positive pregnancy test							Date sent to PCP/RC: [PCSP 1C Factor 4]				1/10/15	
Referral 2	Incoming	*******	*******	**/**/****	10/7 2014	10/8/ 2014	Female	closed	Nurse midwife	<PCP/ Referring Clinician>	<FP Org>	Medium	Chinese-Mandarin
Insurance:	<Name of health plan>												
Reason:	36 Y.O female with Reactive FTA-ABS . PLEASE EVALUATE AND TREAT IF NEEDED. [PCSP 1B: Factor 1] [PCSP 1C: Factor 2]												
Notes:	<Clinician Name> 10/07/2014 10:33:31 AM > pt referred from pcp for further evaluation of syphilis. please asess. labs for rpr/fta-abs scanned into pt												
Assigned To:	<Clinician Name>												
Allergies:	[PCSP 1B Factor 5]												
Diagnosis:	097.9 Syphilis NOS [PCSP 1C: Factor 3]												
Tests Results								Date sent to PCP/RC: [PCSP 1C Factor 4]				10/15/14	

Sample adapted from MIC Women's Health Services.

PCSP Standard 2: Provide Access and Communication

The practice provides timely access to culturally and linguistically appropriate team-based clinical advice and care that meets the needs of patients/families/caregivers.

Element E: The Practice Team

The practice uses a team to provide a range of patient care services by:

Factors

1. Defining roles for clinical and nonclinical team members.
2. Having regular team meetings or a structured communication process focused on patients.
3. Using standing orders for services.
4. Training and assigning care teams to coordinate care.
5. Training and designating care team members in communication skills.
6. Involving care team staff in the practice's performance evaluation and quality improvement activities.
7. Holding regular practice team meetings.

Documentation Requirements:

Factors 1, 4, 5: The practice provides staff position descriptions of clinical team members describing roles and functions. An organizational chart would be helpful in providing information to NCQA about the practice team.

Factor 2: The practice provides a:

- Description of its structured clinical team communication processes about patients that occur regularly, ***and***
- Three samples of team huddles, meeting summaries, agendas or memos to staff or clinicians.

Factor 3: The practice has written standing orders.

Factors 4–5: The practice has a description of its training process and training schedule or materials showing how staff is trained in each area identified in the Factors.

Factor 6: The practice has a description of staff roles in the practice evaluation and improvement process, or minutes from team meetings showing staff involvement.

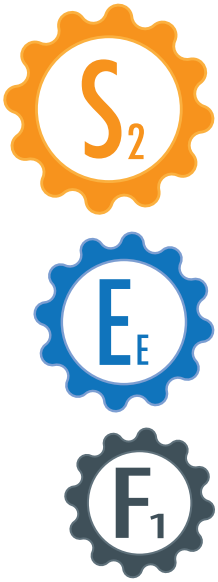
Factor 7: The practice provides a:

- Description of the team meetings, ***and***
- Three samples of meeting summaries, agendas or memos to staff.

NCQA encourages the practice to highlight the information relevant to each Factor in the documentation.

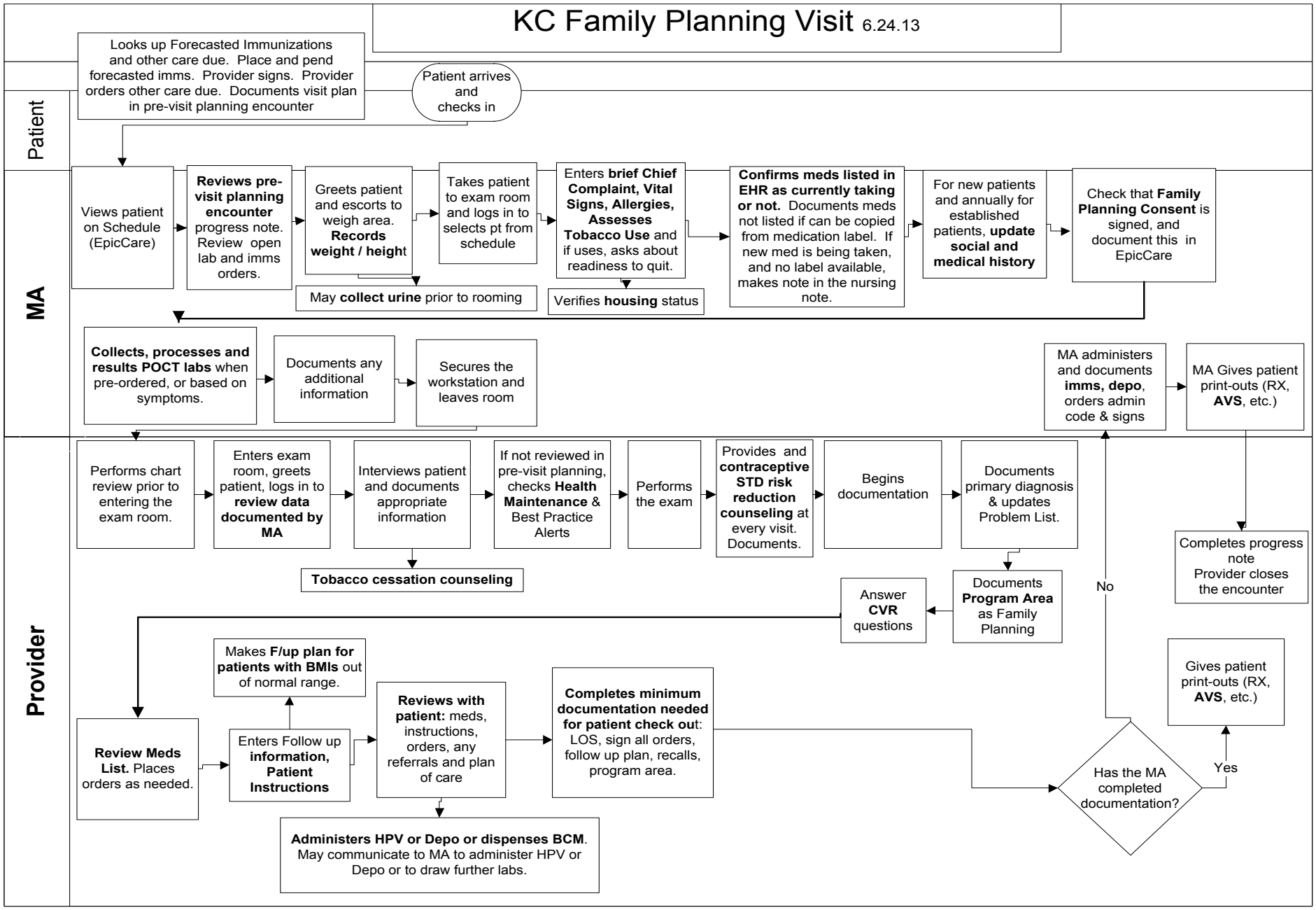
Scoring: A health center must meet three Factors to pass.

EXAMPLE 7: SAMPLE PRACTICE TEAM DESCRIPTIONS, FLOW CHART



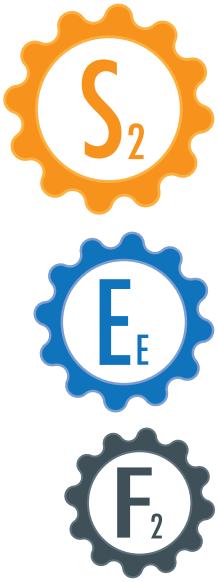
The "practice team" refers to a team of clinical and nonclinical staff who work collaboratively to provide patient-centered care. To pass PCSP Standard 2, Element E, practices must provide evidence that a practice team communicates regularly and works together to enhance patient care.

This flow chart provides a description of the roles and responsibilities of the care team staff during a family planning visit. Alternatively, staff position descriptions that include roles and responsibilities related to being on the care team can also be used as documentation.



Sample adapted from Public Health Seattle King County

EXAMPLE 8: SAMPLE COMMUNICATION PROCESS & MEETING DOCUMENTATION, TEAM HUDDLE TEMPLATE



PCSP Standard 2, Element E, Factor 2, requires a description of the team meeting communication process and three samples documenting team huddles. Patient coordination must be the primary focus of the team meetings; points will not be awarded for meetings that solely address administrative matters (i.e. staff schedule changes or clinic flow).

This example includes a health center's team huddle process and template mechanism to document the meeting – three completed charts would need to be submitted in order to receive points. Team meeting documentation could also be in the form of agendas, meeting summaries, or staff memos.

<Family Planning Organization Name>

Team Huddle Worksheet

Note: Limit huddles to 10 minutes or less - Huddle at a consistent time on a daily basis - Meet in a central location - Stand rather than sit - Take notes – Attendees should be: Providers, NP, RN, LPN, MA, Coordinator, Triage, Reception [PCSP 2E Factor 2 – team communication process]

_____ _____

Provider/Pod Date

_____

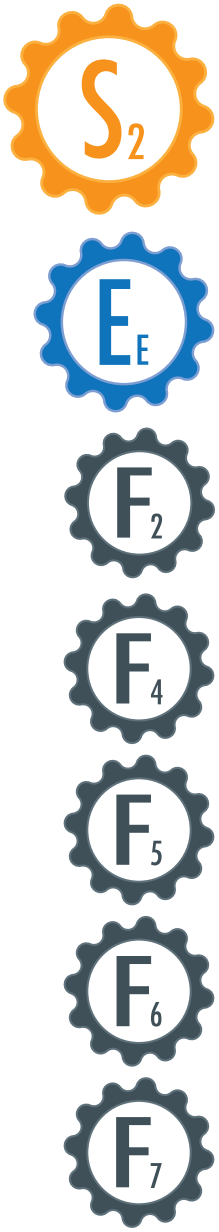
Attendees

[PCSP 2E Factor 2 – meeting documentation]

YESTERDAY - REVIEW	
One thing that went well- what contributed to this?	
What created bottlenecks in workflow?	
How could we have better prepared for the day? Any follow-up needed (specific tests – critical)?	
Any follow-up needed (specific tests – critical)?	
TODAY - PLANNING	
Unexpected absences or shortages?	
Any patients needing additional resources/forms/reports?	
Any patients who will need more time? Less time?	
Any patients physically disabled? Translators needed?	
Patients who are typically late, no-show, or ask many questions?	
Other pre-visit planning	
Any suggestions to make the day flow more smoothly?	
TOMORROW - PREVIEW	
Tomorrow's schedule –proactive planning	
Other Notes	

Biz•Med™ *Adapted from BizMed Solutions*

EXAMPLE 9: SAMPLE COMMUNICATION PROCESS, CARE TEAM COMMUNICATION POLICY



As noted, some Factors require more than one type of documentation. This communication process attests to the meeting and description requirements for Standard 2, Element E, Factors 2, 4, 5, 6, and 7. For Factors 4 and 5, it is also important to include how and which staff members are assigned to certain trainings.

However, each Factor needs additional documentation to receive points. Both Factor 2 and Factor 7 also require three samples of meeting documentation (e.g. meeting summaries, agendas, staff memos). Factors 4 and 5 need an additional description of the roles and functions of the clinical team.

For Factor 6, this example provides a description of staff roles related to evaluation and improvement, but minutes from three team meetings showing staff involvement in quality improvement are also acceptable documentation.

<Practice Name>

<Address>

<City, State Zip>

<Phone>

Policy: Care Team Communications

Purpose: To inform staff on standard communications processes

A. All office staff and providers are expected to participate in practice wide information sharing via the following mechanisms:

	WHEN	WHO	TOPICS
Practice meetings [PCSP 2E: Factor 7]	First Thursday of each month from 12 to 12:45 in the break room	All staff & providers	Issues, announcements, minutes taken
Email	As needed	All staff & providers	Non clinical and non-patient specific issues
EHR messaging	As needed	All staff & providers	All patient specific issues – will be attached to chart Clinical non-patient specific issues
<Add as needed>			

B. Other meetings scheduled for particular groups:

MEETINGS	WHEN	WHO	TOPICS
Huddles [PCSP 2E: Factor 2]	Daily		Patient schedule & related tasks
Front-Office meetings			
Billing meetings			
Outreach meetings			
Cinical staff			
Quality Improvement [PCSP 2E: Factor 6]		All staff	Review performance measures & patient surveys and related action plans
Leadership			
PCSP planning	Every Friday from 1 pm to 2 pm		Strategic planning for PCSP Transformation and NCQA Recognition
<Add as needed>			

C. Education meetings scheduled for staff assigned particular roles (new hires will be provided with self-paced or recorded versions of education programs, and are expected to complete those within the first week of hire). Education/training calendars will be published to staff in January of each year and will be updated by management from time to time. Training sessions are mandatory, unless otherwise specified. [PCSP 2E: Factors 4 and 5]

Approved By:

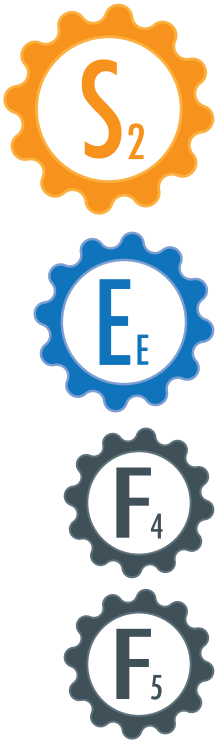
Effective: 7/14/2013

Revised:

Developed from BizMed Solutions

EXAMPLE 10: SAMPLE STAFF TRAINING MATERIALS, EDUCATION AND TRAINING OUTLINE

This staff training documentation clarifies that the staff trainings discussed in Example 9 includes topics required for Standard 2, Element E, Factors 4 (care coordination) and 5 (vulnerable populations). Training materials related to care coordination and vulnerable populations are also acceptable forms of documentation.



<Practice Name>

<Address>

<City, State Zip>

<Phone>

Education and Training – Self Paced

All Staff (except providers): September-November 2014

Completion sheets to be turned in by Monday 12/1/14

SUBJECT	TRAINING	HYPERLINK (CLICK TO WATCH)	COMPLETED	COMPLETION DATE
Care Coordination [PCSP 2E: Factor 4]	Team-based Care Model - AAFP	http://www.aafp.org/practice-management/pcmh/overview/videos.html?cmpid=_van_538	☐	
Patient Self-management	Patient Self-management Support - AAFP	http://www.aafp.org/practice-management/pcmh/overview/videos.html?cmpid=_van_539	☐	
Population Management [PCSP 2E: Factor 5]	Quality Solution Navigator - Diabetes	http://communitynursecaremanagers.qualitysolutionnavigator.com/	☐	
Patient Communications [PCSP 2E: Factor 5]	Health literacy and patient safety: Help patients understand	http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-video.page? http://www.youtube.com/watch?v=cGfTZ_vxjyA	☐	
Referral Communications [PCSP 2E: Factor 4]	Best practices in communicating with PCP and other referring organizations/ clinicians	http://www.bestpractices.com	☐	

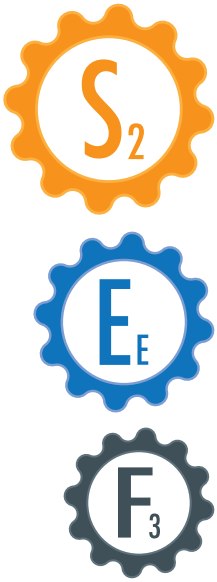
Team Member Name: _____ Team Member Role: _____

Developed from BizMed Solutions

EXAMPLE 11: SAMPLE POLICY, STANDING ORDERS

The use of standing orders can improve access to timely care by expanding the scope of services that can be provided by a range of clinicians, and are seen as vital part of the care team.

Standard 2, Element E, Factor 3 requests evidence that standing orders are utilized by the practice team. The content of the standing order should be related to the specialty.



<Family Planning Organization Logo>

INFLUENZA IMMUNIZATION CONSENT

ORGANIZATION ACCOUNT # _____

CONTRADICTIONS – INFLUENZA

I have not been previously immunized this flu season *(No he recibido vacuna contra influenza anteriormente)*

I am not allergic to eggs or Thimersol (preservative in contact lens solution) *(No soy alérgica a los huevos)*

I have not had a previous reaction to influenza vaccine or history of Guillain-Barre syndrome *(No he tenido una reacción adversa a la vacuna anteriormente)*

I do not have acute febrile illness *(No tengo fiebre o gripe)*

Patient Agreement *(El Acuerdo del Paciente)*:

I have been given information about influenza vaccine and understand the risks and benefits of the vaccination.
(Yo he recibido información acerca de la vacuna de la influenza. Y entiendo los riesgos y beneficios de la vacuna.)

I request the vaccination be given to me. *(Yo pido que se me de la vacuna.)*

Signature *(firma)* _____

Date *(fecha)* _____

PROVIDER'S ORDER:

STANDING ORDER: <NAME OF PROVIDER> ALL PRENATAL PATIENTS MUST BE OFFERED AND ENCOURAGED TO BE VACCINATED. PRENATAL PATIENTS WHO REFUSE THE VACCINE MUST SIGN THE REFUSAL SECTION BELOW. ALL FP AND GYN PATIENTS MAY BE OFFERED THE VACCINATION. [PCSP 2E: Factor 3]

VACCINE ADMINISTRATION:

SEASONAL INFLUENZA VACCINE

Type of Vaccine: FLUVIRIN

Single Dose: 0.5mL

IM site (circle): R L deltoid

Manufacturer: NOVARTIS VACCINES- Expires 03/2015

Circle Lot # 145302 145303

Administered By: _____ Date: _____

EMPLOYEE/PRENATAL PATIENTS: REFUSAL TO BE VACCINATED (NO QUIERO VACUNARME)

INFLUENZA VACCINE INDICATED BUT NOT GIVEN *(LA VACUNA ESTA INDICADA PERO NO FUE ADMINISTRADA):*

_____It was recommended that I receive the influenza vaccination *(Se recomienda que yo me vacuna contra la influenza).*

_____ I have refused because *(No quiero vacunarme porque-elige la razón):* (CIRCLE ONE)

Believes not at risk *(No creo que corro riesgo)*

Believes vaccine will not work *(Creo que la vacuna no trabaja)*

Fear of adverse effects *(Le tengo miedo a los malos efectos)*

Wants further advice (e.g., MD, family) *(Necesito consejo de doctor, familia, etc…)*

Would rather receive elsewhere *(Prefiero recibirla en otro lugar)*

Other *(Otra razón)* _____

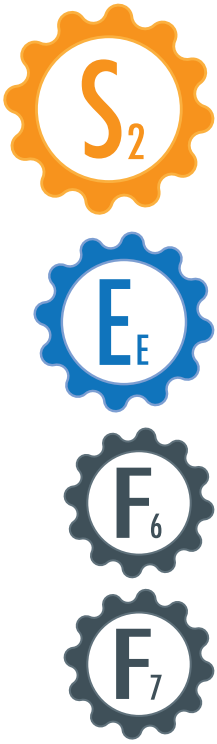
Signature *(Firma)* _____

Date *(fecha)*_____

Reviewed: 10/08, 9-09, 9/10, 11/10, 5/11, 9/12, 9/13
Effective: 7/1/2014
Implementation 9/2/14

Sample adapted from MIC Women's Health Services.

EXAMPLE 12: SAMPLE POLICY, QUALITY ASSURANCE-MANAGEMENT



PCSP Standard 2, Element E recommends that the care team be engaged in a health center's performance evaluation and quality improvement activities (Factor 6). In addition, practices are expected to hold regularly scheduled meetings that include clinical and non-clinical staff to discuss health center operations (Factor 7).

This example provides a description of staff roles in practice evaluation and improvement to attest to Factor 6. Minutes from team meetings showing staff involvement can also be used.

This example also gives the team meeting description required for Factor 7. Three examples of meeting summaries, agendas, or memos to staff are also required.

<Family Planning Organization>

QA & Compliance Section

QUALITY ASSURANCE-MANAGEMENT

Purpose: The overall objectives of the <Family Planning Organization's> Quality Assurance Program are:

1. To monitor the implementation of the Vision with its associated Principles of Practice and Model of Care.
2. To monitor the quality and appropriateness of services to patients involving all members of the staff as active team members in the quality assurance and improvement processes. [PCSP 2E: Factor 6]
3. To assure compliance with:
   - all applicable local, State and Federal requirements
   - accepted standards of practice within the obstetrical and gynecological field and related services
   - all current grant and contract obligations
   - all current and future managed care contract requirements.

Components: The essential components of the Quality Assurance/Management Program are:

1. Management of Quality of Clinical Care:
   - Regular and interdisciplinary record review is the method to be used to manage the quality of the care rendered at centers. Records review will be conducted at each center by the professional teams and at central office by a team composed of the Vice President, Public Health Programs, the Medical Director and the Center Director. Agreed upon record review tools will be used uniformly for the record review. These tools will be designed and revised as needed to reflect the most current State, local and Federal regulations and the clinical protocols included in this Manual.
   - Review tools will be revised as indicated to reflect the changes in guidelines, if any, and the changes in clinical issues that must be addressed and monitored throughout the Family Planning Organization.
   - Issue specific record reviews will be conducted at each center or organization-wide when a clinical issue is identified through the other components of the Quality Assurance/Management Program.

2. Monitoring of Center Specific and Organization-wide Performance Indicators
   - Performance Indicators will be chosen on an annual basis to monitor performance at each center and across the Family Planning Organization. The issues will across disciplines, clinical, financial, information systems, facilities management and others they will be chosen by the Quality Management Group. Examples include but are not limited to: # visits against projections, expenses vs. revenues, percentage of women returning for post-partum care, percentage of family planning patient using "effective" contraception.

3. Monitoring of Patient Satisfaction and of Community Needs
   - Focused patient satisfaction surveys are performed at each center according to an annual plan formulated by the Quality Management Group. These studies will take the "pulse" of patients and their satisfaction with the way their concerns are addressed or new programs are planned/implemented. Information from these studies will be shared with managers on a quarterly basis to inform change procedures and/or services, plan for training of staff and other activities affecting patient care. [PCSP 2E: Factor 6]
   - The Education and Information Committee composed of members of the community including patients served by the Family Planning Organization. This committee serves two purposes: review of the appropriateness of the educational material used at the Family Planning Organization and review of the proposed changes/additions in clinical services. The Medical Director (or designee, such as the Organization Director) will provide leadership to this group and ensure that it meets at least quarterly, minutes are kept and information forwarded to the Quality Management Group.

- Quarterly Community Advisory/ Program Review Committee will meet quarterly to review program needs, community changes as they relate to the Family Planning Organization, community resources available to improve the patient experiences and well as to assure compliance with regulatory standards.

4. Monitoring of Licenses (see Procedure below)
   - Providers (MDs, CNMs, NPs, Medical Director, and other licensed providers as needed):
   - Nursing staff
   - Social workers

5. Identification of Quality Issues, Coordination and Monitoring of Plan of Corrections – Annual QA Plan

Three groups of staff manage quality issues:

- The QUALITY MANAGEMENT GROUP (QMG) has the overall responsibility for ensuring the timely identification and follow-up of issues that affect quality care, and that corrective actions are satisfactorily completed and monitored. The QMG is composed of an interdisciplinary group of the Center Director, Vice President, Public Health Programs, Medical Director, and the Director. The group meets Quarterly to address operational and quality assurance issues, to develop corrective action plans and to monitor that these plans are completed or redeveloped as needed. The agenda for these meetings is the result of issues raised by center staff, social work, and provider meetings through their written minutes, copied to senior staff. Minutes are kept of each QMG meeting and distributed to attendees and senior staff.

Quality issues are addressed:

- QMG meeting: attendees raise issues identified at center specific meetings, chart reviews, studies and /or any of the other meetings that regularly take place. [PCSP 2E: Factor 7]. As indicated, they are attended by the QMG and other staff members such as Center Director and representatives of the provider staff. Indicators, trends identified during chart review, lab utilization patterns and results from focused patient satisfaction studies are shared and discussed resulting in revision to protocols. [PCSP 2E: Factor 7]
- CENTER STAFF MEETINGS are held at a minimum monthly and are attended by all center staff and as many providers as possible. Interdisciplinary case conferencing, coordination of care, chart review findings and operational issues are discussed and/or identified for resolution by the center or for the Center Director to present at the next QMG. [PCSP 2E: Factor 7]
- PROGRAM REVIEW MEETINGS are held quarterly and are attended by the Director level staff- VP, Senior Director, Medical Director and Center Director to review the operations and areas of concern that have been raised in the QI and staff meetings held during that quarter.

Revised: 4/09, 06/12, 6/13 Effective: 7/1/2014 Implementation: 9/4/2014

Sample adapted from MIC Women's Health Services.

PCSP Standard 4: Plan and Managed Care;

The practice collaborates with the referring clinician and the patient/family/caregiver to plan and manage care and provider self-care support.

Element B: Medication Management

The practice has a process and demonstrates that it systematically manages medications prescribed by the practice in the following ways:

Factors

1. Reviews and reconciles medications for more than 50 percent of patients received from another care setting or at a relevant visit.++/+
2. Provides information about new prescriptions from specialty practice to patients/families/caregivers.
3. Coordinates medication management and reconciliation with the PCP, referring clinician (if applicable) and patient/family/caregiver.
4. Assesses patient/family/caregiver understanding of medications from specialty practice.
5. Assesses patient response to medications from specialty practice and barriers to adherence.
6. Documents over-the-counter medications, herbal therapies and supplements.

++/+ Stage 1 Menu/Stage 2 Core Meaningful Use Requirement (To the extent possible, PCSP Standards are aligned with CMS Meaningful Use (MU) requirements. Individual Factors are identified in the Standards as either Menu or Core MU with ++ or + symbols)

Documentation Requirements:

Factor 1: The practice provides a report showing that more than 50% of patients received from another care setting or at a relevant visit had medications reviewed and reconciled.

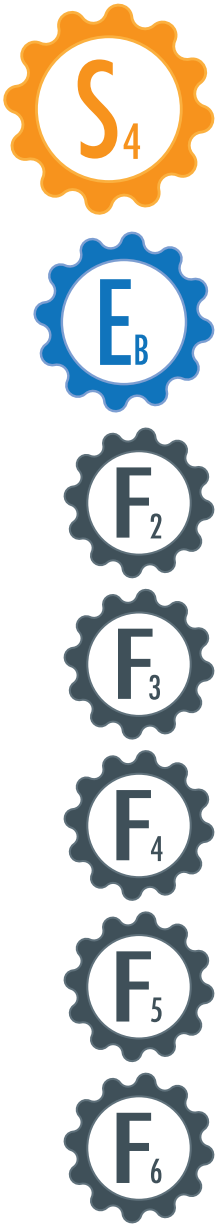
- Denominator = Number of patients seen by the practice in the reporting period
- Numerator = Number of patients in which their medications were reviewed

Factors 2–6: The practice provides a:

- Documented process for staff to follow for managing the medications prescribed by the practice, ***and***
- Three examples for each Factor.

Scoring: A health center must meet three Factors to pass.

EXAMPLE 13: SAMPLE DOCUMENTED PROCESS, MEDICATION MANAGEMENT POLICY



Maintaining a current list of a patient's medications and resolving any related conflicts to reduce the possibility of duplicate medications, errors, or adverse drug events is essential to patient-coordinated care.

A documented process to guide staff in managing medications prescribed by the practice is required for Factors 2-6. In addition, three examples for each Factor should be provided.

<Family Planning Organization>

MEDICATION MANAGEMENT

Purpose:

To assure that all patient records regarding medication, including that which is prescribed in an external care setting, are maintained and updated regularly.

Procedure:

RESPONSIBLE PARTY	ACTION
Providers	• Review and reconcile medications for: ▸ All patients who are new to the practice ▸ All patients who were seen in the ED or hospital [PCSP 4B Factor 3] ▸ All patients who receive medications from an out of system provider [PCSP 4B Factor 3] • Record all medication information discussed with patient/caregiver, including any potential side effects, drug interactions instructions, and consequences of not following the prescription. [PCSP 4B Factor 2] • Document over the counter medications, herbal therapies and supplements. [PCSP 4B Factor 6] • Reconcile medication at each visit for all patients. • Ensure that patient understands and provides input into likelihood of compliance. [PCSP 4B Factor 4] • Record patient response to medications and barriers to adherence. [PCSP 4B Factor 5]
Providers	• Write eligible prescriptions in EHR • Sent prescriptions to the pharmacy electronically

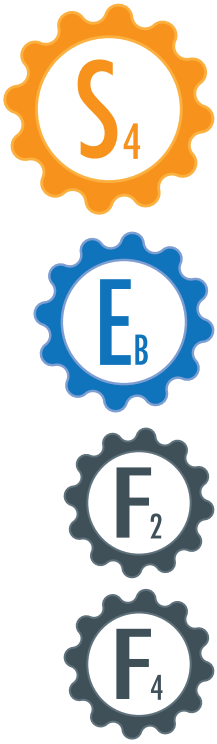
Effective: 7/1/2014

Sample adapted from MIC Women's Health Services.

EXAMPLE 14: SAMPLE REPORT, MEDICATION MANAGEMENT

As noted, in addition to a documented process, three examples of communication are required for each Factor, 2-6.

This example reflects notes in a patient's EHR and has been modified for clarity and confidentiality. It provides one example for Factors 2 and 4; two more examples are needed to receive points those Factors.



Patient Name _____ Provider _____

Account number _____ Date _____

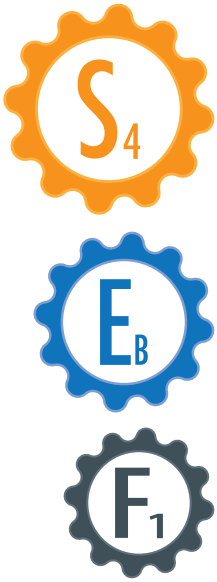
Medications: Taking Plan B (MIC) 0.75 MG Tablet as directed, Taking Microno (MIC) 0.34 MG Tablet 1 tablet once a day, Discontinued Depo-Provera (MIC) 150 MG/ML 1ML, Discontinued Griseofulvin, Medication List was reviewed and reconciled with the patient.

Allergies: NKDA

IUD Counseling: EDUCATION: IUD pamphlet given to patient [PCSP 4B Factor 2], on how to check for strings, practices, possible side effects; Pt verbalized understanding [PCSP 4B Factor 4], Written information given <clinician name> 11/25/14 10:20:25 a.m.

Sample adapted from MIC Women's Health Services.

EXAMPLE15: SAMPLE REPORT, MEDICATION RECONCILIATION



Standard 4, Element B, Factor 1 requires a report that shows at least 50% of patients who have another provider had medications reviewed and reconciled.

Factor 1 aligns with CMS Meaningful Use requirements and a meaningful use report is an acceptable form of documentation - this report has been modified for clarity, but it is acceptable to submit a scanned copy of the report to NQCA.

The report does not have to be based on meaningful use, but must include a denominator (number of patients seen by practice in the reporting period) and numerator (number of patients in which their medications were reviewed) showing that more than 50% of patients receiving care at another setting had medications reviewed and reconciled.

<Clinician Name> [XXXXXX]

<Health Center>

NPI: XXXXXXXXXX

Stage 1/Year 2

Medicaid

PQRS EHR Direct Indvidual

!The data show for this provider is not valid for attestation because providers in Stage 1/Year 2 need to attest on a full-year summary data, but the reporting period is **not** a full year.

Stage 1 Objectives

Reporting Period 1/1/2015–3/31/2015

Core Measure (10/13)	Threshold	Score
C1/P101: Enter Orders Using CPOE (Patient-Based)	> 30%	100% ✓ 123 of 123 Patients
C1/P101B: Enter Orders Using CPOE (Orders-Based)	> 30%	100% ✓ 200 of 200 Patients
C2/P102: Implement Drug-Drug and Drug-Allergy Checks		No data found
C3/P104: Maintain an Active Problem List*	>80%	100% ✓ 144 of 145 Patients
C4/P105: Monitor Use of E-Prescribing (Objective excluded: Requires 100 prescriptions)	> 40%	35% ✓ 11 or 32 Patients
C5/P106: Maintain Active Medication List *	> 80%	99% ✓ 143 of 145 Patients
C6/P107: Maintain Active Allergy List*	> 80%	100% ✓ 144 of 145 Patients
C7/P108: Record Patient Demographics*	> 50%	100% ✓ 145 of 145 Patients
C8/P109: Record Vitals*	> 50%	100% ✓ 144 of 145 Patients
C9/ P110: Record Smoking Status	> 50%	100% ✓ 145 of 145 Patients
C10/P116: Implement Clinical Decision Support		No data found
C11/P119: Provide Electronic Access for Patients*	> 50%	51% ✓ 73 or 145 Patients
C12/P120: Provide Patient with an After Visit Summary	> 50%	85% ✓ 130 or 153 Visits
C13/P128: Protect Electronic Health Information		No data found
M4/P112: Incorporate Clinical Lab Test Results	> 40%	100% ✓ 202 of 203 Patients
M4/P112: Incorporate Clinical Lab Test Results	> 40%	100% ✓ 202 of 203 Patients
M6/P115: Send Reminders to Patients (Objective excludes: Requires 1 patient)	> 20%	N/A – 0 of 0 Patients
M7/ P121: Provide Patient with Education Resources*	> 10%	72% ✓ 103 of 145 Patients
M8/P123: Reconcile Medications for Transitions of Care [PCSP 4B1]	> 50%	82% ✓ 30 of 37 Transitions
M9/P124: Provide a Summary of Care Record for Transitions of Care	> 50 %	N/A – 0 of 0 Transitions

* According to the Final Rule, these measures require the eligible professional to count all patients, not just those in EHR

Report Version Epic – DLG #XXXXXXXX

Run on: 4/20/2015 at 1:18 PM

Sample adapted from Public Health Seattle King County.

EXAMPLE 16: SAMPLE PATIENT COMMUNICATION, PATIENT BROCHURE

This example of a patient brochure encourages patients to help manage their medications and helps explain the importance of communicating with their primary care provider about all current medications. This supports the expectation that patient/family/caregiver are involved in the reconciliation of medications.

Three examples of communication between the specialty practice and a primary care provider regarding patient medication reconciliation are also needed.

It is important to be prepared for visit:

It is helpful for us to know when and where you had your last pap test. Please tell us this information at your visit, if possible.

It is also helpful for us to know what medication you are taking. Please bring in your medicine bottles or a list of your medications and doses, if possible. **[PCSP 4B, Factor 3]**

Your Care Team:

Your provider is a nurse practitioner who works with medical assistants, schedulers and other clinic staff.

When we need to reach you after your visit:

Please make sure you give us a phone number where we can call you for test results or to call you when you are due for certain services.

For all lab test results, including the pap test, we will call you with abnormal results.

For test results that are not normal and need follow up, if we cannot reach you by phone, after calling you three times, we will send a letter to the address you give us.

If you don't hear from us and are worried about your results you can call us at 206-477-8000.

Talking with your Primary Care Provider

We want to better coordinate your care with your doctor. It helps your doctor know what services we've provided you. This will help make your health better. **[PCSP 4B, Factor 3]**

For our adult female patients, after your visits, we will write a letter telling your doctor what STD, HIV and Pap tests and results, and medication, including birth control, we have given you, and the plan for on-going care.

If you do not want us to tell your doctor about your visits or if there is certain information you do not want us to share with your doctor, please tell the front desk staff and you will need to fill out a form. [PCSP 4B, Factor 3]

Working with you to meet your goal

We want to support you in successfully deciding for yourself if you want to be pregnant and when.

We also want to help you keep your body healthy from STDs and certain cancers.

We will work with you to help you develop a plan based on your pregnancy goals.

As your needs change, we will continue to work with you to meet your new goals.

Sample adapted from Public Health Seattle King County.

PCSP Standard 6: Measure and Improve Performance

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.

Element C: Implement and Demonstrate Continuous Quality Improvement

The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:

Factors

1. Setting goals and acting to improve on at least three clinical quality or utilization measures.
2. Setting goals and acting to improve quality on at least one patient experience measure.
3. Setting goals and acting to improve timeliness of patient access.
4. Setting goals and acting to improve coordination with primary care.
5. Tracking results over time.
6. Assessing the effect of its actions.
7. Achieving improved performance on one measure.
8. Achieving improved performance on a second measure.
9. Setting goals and addressing at least one identified disparity in care/ service for vulnerable populations.

Documentation Requirements:

Factors 1–4: The practice provides reports ***or*** a completed PCSP Quality Measurement and Improvement Worksheet.

Factor 5: The practice provides reports, NCQA's clinical recognition program results ***or*** a completed PCSP Quality Measurement and Improvement Worksheet showing performance measures over time.

Factor 6: The practice provides reports ***or*** a completed PCSP Quality Measurement and Improvement Worksheet on improvement activities and the results.

Factors 7–8: The practice provides reports, NCQA's clinical recognition program results ***or*** a completed PCSP Quality Measurement and Improvement Worksheet showing improvement on performance measures.

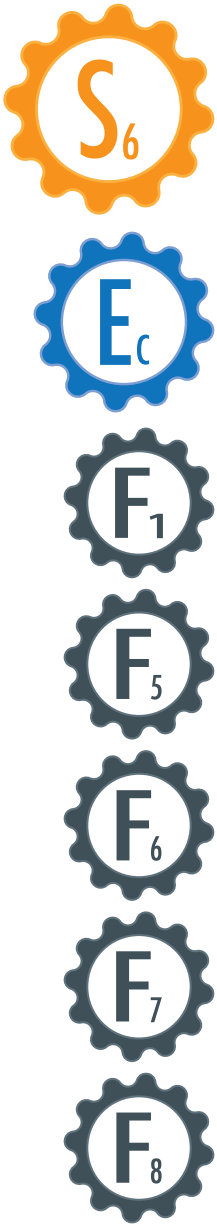
Factor 9: The practice provides reports ***or*** a completed PCSP Quality Measurement and Improvement Worksheet.

Scoring: A health center must meet 3–4 Factors to pass.

EXAMPLE 17: QUALITY MEASUREMENT AND IMPROVEMENT WORKSHEET

Documentation for PCSP Standard 6, Element C can be presented through agency reports or the completion of the PCSP Quality Measurement and Improvement Worksheet (QMIW). The QMIW is housed in and can be downloaded from NCQA's online application.

For Factor 1, it is critical that the three clinical quality or utilization measures selected be related to the specialty. It is beneficial to explain how measures are related to sexual and reproductive health, as reviewers may not have this knowledge.



Quality Measurement and Improvement Worksheet
<Family Planning Organization>

MEASURE	OPPORTUNITY IDENTIFIED	INITIAL PERFORMANCE/ MEASUREMENT PERIOD [PCSP 6C FACTOR 5]	PERFORMANCE GOAL [PCSP 6CFACTOR 1, GOAL]	ACTION TAKEN/DATE OF IMPLEMENTATION [PCSP 6CFACTOR 6]	PERFORMANCE AT RE-MEASUREMENT PCSP 6 ELEMENT C	DEMONSTRATED IMPROVEMENT [PCSP 6C FACTORS 7–8]
CLINICAL						
Use of Effective Contraceptive [PCSP 6C: Factor 1, Measure #1]	During 1/1/12 - 11/30/12 - about half of our patients left with a birth control method that is classified as not being highly effective. This includes any method that is not sterilization, hormonal, IUDs, or implants.	% of patients leaving on an effective method during the time period 1/1/13 through 11/30/13. 1/2013 – 46% 3/2013 – 44% 6/2013 – 55% 9/2013 – 68% 11/2013–71%	70% of patients will leave with an effective method.	In January 2013 we hired a consultant to assist in the implementation of a plan to improve the use of effective contraception for all patients not seeking pregnancy. The Plan Do Study Act (PDSA) process was started in March 2013	% of patients leaving on an effective method during the time period 1/1/14 through 11/30/14, 1/2014 – 56% 3/2014 – 68% 6/2014 – 67% 9/2014 – 70% 11/2014–69%	During the 1 year measurement and quality improvement period, we saw improvement in patients leaving on an effective method (e.g. Starting at 46% and improving to 69% which is very close to the goal of 70%
Hypertension [PCSP 6C: Factor 1, Measure #2]	During 1/1/14-3/31/14 -19 hypertensive patients who required follow-up were identified.	% of patients with hypertension who received f/u counseling (as documented in their medical record) 1/1/14 - 3/31/14 – 47%	75% of patients with hypertension will receive follow-up counseling.	Developed Hypertension Report that pulls data from the EHR to identify patients in need of f/u counseling. Staff and providers reminded to provide counseling and education to patients as well as to encourage patients to follow-up with their PCP. Both implemented in April 2014.	% of patients with hypertension who received f/u counseling (as documented in their medical record) 4/1/14 – 6/30/14 – 53% [PCSP 6C FACTOR 7]	During the 6 month measurement period, the Hypertension Report was developed and used to review and discuss the measure at the Quality Assurance (QA) meetings with all staff. Since the implementation of the report and regular discussions at the QA meetings about the need for counseling of hypertensive patients and the importance of accurate documentation in the record, there has been improvement in the documented f/u counseling of patients with hypertension from 47% in Q1 of 2014 to 53% in Q2 2014. This process will continue to be reviewed as we work toward the goal of 75%.
BMI [PCSP 6C: Factor 1, Measure #3]	During 4/1/2014-6/30/2014 -269 patients were identified as overweight or obese and required counseling.	% of patients that were overweight or obese and received f/u counseling (as documented in their medical record). 4/1/14 - 6/30/14 – 67%	90% of overweight/obese patients will receive counseling that is documented in their medical record	Developed BMI Report that pulls data from the EHR and used to identify patients in need of f/u counseling Staff and providers reminded to provide education and document the plan to address patients with high BMI. Both implemented in April 2014	% of patients that were overweight or obese and received f/u counseling (as documented in their medical record). 7/1/14 – 9/30/14 – 76% [PCSP 6C FACTOR 8]	During the 6 month measurement period, the BMI Report was developed and used to review and discuss the measure at the Quality Assurance meetings with all staff. Since discussion about the need for counseling of overweight/obese patients and the importance of accurate documentation in the record, there has been improvement in the documented f/u counseling from 67% to 76%.

Sample adapted from MIC Women's Health Services.

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

To that end, NFPRHA seeks to maximize the opportunities for protecting and expanding access to family planning services for vulnerable populations by advocating for programs and resources that enhance both the medical services provided through and infrastructure of the publicly funded safety net.

Furthermore, NFPRHA prepares its membership for changes in the health care economy by providing policy and operational analyses to help its members consider and execute strategies for adapting to evolving economic and policy climates, and by convening administrators and clinicians to share experiences and best practices that help enhance quality and service delivery.

National
Family Planning
& Reproductive Health Association

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