Patient-Centered Specialty Practice Designation

#NFPRHA1
NCQA’s Patient-Centered Medical Home and Patient-Centered Specialty Practice Recognition Programs
What are the PCMH and PCSP Programs?

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

The PSCP Recognition program extends these medical home concepts to specialists.
Why pursue PCMH or PCSP?

• What are the benefits?

• What does it take to achieve it?

• Is it worth the work?
Who is eligible for the PCMH and PCSP programs?

PCHM eligibility

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

PCSP eligibility

• Nonprimary care specialty docs, NPs, PAs, certified nurse midwives, behavior health providers
The Vision for a PCMH

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

Medical homes can lead to higher quality and lower costs, and can improve patient and provider experiences of care.
The Vision for a PCSP

Patient-centered specialty practices demonstrate patient-centered care and clinical quality. They use streamlined referral processes and coordinate care with referring clinicians. They have timely patient and caregiver-focused care management and conduct continuous clinical quality improvement.
What do PCMHs and PCSPs do, and how do they do it?

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

- Lower costs
- Better care
- Higher satisfaction
What does it take to achieve recognition?

• Leadership and Practice Culture
  – Commitment to Transformation
  – Commitment to Patient-Centered Care
  – Commitment to Team-Based Care

• Formal Approach to Quality Improvement
What does it take to achieve recognition?

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

Note: Some organizations report up to 800 hours of staff time to make changes, document processes, and submit paperwork.
What are the “nuts and bolts” of the NCQA PCSP Process?
Areas of Focus for PCSP (The Standards)

PCSP focuses on the following:

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

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<tr>
<th>Standard</th>
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<tr>
<td>Track and Coordinate Referrals</td>
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<tr>
<td>Provide Access and Communication</td>
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<tr>
<td>Identify, Coordinate Patient Populations</td>
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Elements

PCSP 1: Track and Coordinate Referrals

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:

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

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
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<tbody>
<tr>
<td>The practice meets 6-8 factors</td>
<td>The practice meets 4-5 factors</td>
<td>The practice meets 2-3 factors</td>
<td>No scoring option</td>
<td>The practice meets 0-1 factors</td>
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Overall Scoring

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

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

- www.ncqa.org
- Toolkit (in process)
- NCQA staff
- TA providers
- “Early Adopters”
Patient-Centered Specialty Practice Recognition

Henrietta S. Milward, RN, BS, PCMH CCE

April 27, 2015
National Committee for Quality Assurance (NCQA)

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

MISSION
To improve the quality of health care.

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

ILLUSTRATIVE PROGRAMS
* HEDIS – Healthcare Effectiveness Data and Information Set
* Health Plan Accreditation * Clinician Recognition/PCMH/PCSP
* Disease Management * ACO Accreditation
* Wellness & Health Promotion Accreditation
* Health Plan Rankings * Case Management Accreditation
Atul Gawande on Fragmented Care.....

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

From NCQA’s December 2012 Policy Conference
Addressing the Burden of Uncoordinated Care

Lack of Care Coordination Can Lead to Complications

Pain
Wasteful Spending
Unnecessary Procedures
Medical Errors

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

Leading us one step closer to achieving the triple aim

Population Health
Experience of Care
Per Capita Cost

The Medical Neighborhood is the answer...

- **More efficient use of services**
  Lab, imaging, ER, hospitalization, return to PCP, systematic patient care management, EHR, generic medications

- **Improved patient experience**
  Access, coordination, clinician collaboration, involvement in care

- **Improved outcomes**
  Continuous quality improvement, use of evidence-based guidelines, medication management
Future of Reimbursement- Payments Tied to Value

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

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

HHS has set a goal of tying 30 percent of traditional, fee-for-service, Medicare payments through alternative payment models, such as Accountable Care Organizations (ACOs), to performance and quality measures by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

In the midst of the health care system transformation, HHS has set a goal of tying 50 percent of all traditional Medicare payments to quality or value by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Quality Improvement Programs. This is the first time in the history of the Medicare program that HHS has set goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with states, payers, employers, consumers, providers, and public- and private-sector entities to promote adoption of alternative payments models through their own aligned work, as well as expanded Medicare. The Network will hold its first meeting in March 2015, and continue in the near future.

“Whether you are a patient, a provider, a business, or a city or state government, we all have a role to play when it comes to improving the health care delivery system,” said Secretary Burwell. “Today’s announcement is about improving quality with the same time spending our health care dollars on transforming the care our people receive.”

Major providers, insurers plan aggressive push to new payment models

By Melanie Espino / January 28, 2015

[Story updated at 12:30 p.m. ET] Several of the nation’s largest health systems and insurers are joining together in a new task force with the goal of shifting 75% of their business to contracts with incentives for quality and lower-cost care. The Health Care Transformation Task Force includes some of the largest U.S. health systems, including Ascension, St. Louis, and Trinity Health, Livewell, Mich., and insurance giants Aetna and Health Care Service Corp. Employer-Care, Entertainment and the Pacific Business Group on Health. Force members said they would make a “no regrets” promise, as the force is regional gaps in health care.
Care Integration and Coordination

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

Patient-Centered Specialty Practice (PCSP): Coordinated Care

Patient-Centered Medical Home (PCMH): “Whole Person” Comprehensive Care
Why Coordination of Care?

• PCPs and specialists can **benefit from structure and guidelines** to establish and maintain good communication\(^1\)

• Effective collaborative arrangements may result in **reduction in use of unnecessary care**\(^2\)

• **State and private payer** PCMH initiatives include specialists (e.g. VT, BCBSNC)

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Commercial Payer Incentives Programs Using PCSP Recognition

Legend
*States with multiple initiatives are striped.

- PCSP Recognized practices

- Anthem
- BCBSNorth
- Promedica/Paramount Health Plan
- HealthSpan
- UPMC Health Plan

*Includes the District of Columbia
Recognitions by Specialty Type

- Infectious disease
- Gastroenterology
- Pulmonary medicine
- Cardiology
- Endocrinology
- OBGYN
- Oncology

Psychiatry (Autism clinic)
Pediatrics
Pulmonary medicine
Rheumatology
Orthopedics
Physical/Rehab medicine
Surgery
Wound care
Genetics
Vascular care
Occupational medicine
Ophthalmology
Immune deficiency, Nephrology

Numbers of practices recognized

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

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

- Leadership
- Resources
- Team-based Care
- Formal Approach to Quality Improvement
- Practice Culture
- Health Information Technology
Why Become a PCSP?

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

Visit NCQA Web Site at [www.ncqa.org](http://www.ncqa.org) to:
- Follow the Start-to-Finish Pathway
- View Frequently Asked Questions
- View Recognition Programs Training Schedule

Contact NCQA Customer Support at 1-888-275-7585
M-F, 8:30 a.m. - 5:00 p.m. ET to:
- Acquire standards documents, application account, survey tools
- Questions about your user ID, password, access

For questions about interpretation of standards or elements to [My NCQA](http://my.ncqa.org)
Select Policy/Program Support - Recognition Programs
Our PCSP Experience

Sandra Williams, MPA
Senior Director, MIC Women’s Health Services
Objectives

- Understand the certification process
- Understand the organizational commitment:
  - Before, during, and after recognition
The PCSP Recognition Process

Start-to-Finish

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

BEFORE LEARN IT

- Are you eligible for Patient-Centered Recognition (PCMH or PCSP)?
  - Yes → Get the FREE Standards & Guidelines for your program.
  - No → Do you want to proceed toward Patient-Centered Recognition?

DURING EARN IT

- Order FREE online application.
- Do you have 3 or more practice sites?
  - Yes → Obtain multi-site approval.
  - No → STOP!

- Attend FREE software training (at least 30 days before submitting ISS Survey Tool).
- Purchase ISS Survey Tool.
- Submit online application.
- Prepare and submit ISS Survey Tool to NCQA.
- NCQA reviews ISS Survey Tool (30-60 days).

AFTER KEEP IT

- Promote your NCQA Recognition status.
- Upgrade your NCQA Recognition status.
- Maintain your NCQA Recognition status.
Scoring

Assess sites against Standards & Guidelines
PCSP Recognition Standards

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

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

• Administrative:
  ▫ More detailed information recorded, tracked (clinical guidelines, medication reconciliation)
  ▫ Patient Portal
  ▫ Update Referral tracking & EHR documentation

• Clinical:
  ▫ Coordination/Management of Care
Organizational Commitment

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

• Short-Term:
  ▫ Improved communication with patients
  ▫ Improved coordination with other physicians

• Long-Term:
  ▫ Improve quality of patient experience
  ▫ Create channels for more referrals, increase patient flow
  ▫ Leverage for reimbursement contracts with Managed Care Plans
Challenges

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

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

Sandra Williams, MPA
Senior Director of MIC Women’s Health Services
swilliams@healthsolutions.org
Patient-Centered Specialty Practice

Adagio Health Inc. – Western PA Title X Grantee

Linda Snyder, DrPH
A bit of history…

- Adagio Health was in the process of accreditation through the AAAHC
- NFPRHA’s *Leadership Learning Collaborative* opportunity
- CDC/OPA – Quality Family Planning Guidelines
Comparing QFP with PCSP…

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

**NCQA - PCSP**
1. Track & Coordinate Referrals
2. Provide Access & Communication
3. Identify & Coordinate Patient Populations
4. Plan & Manage Care
5. Track & Coordinate Care
6. Measure & Improve Performance
PCSP Corporate Application

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

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

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

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

• Ask questions – don’t assume you completely understand what’s required for documentation!

• Establish processes – step by step processes that clearly outline each step a staff takes in providing certain services

• Pay attention to data collection and set up your system – early in the process – to make sure you can track what’s happening

• Network

Talk to people who’ve gone through the process
Lessons Learned, page 2

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

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