
PCSP
RECOGNITION

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Patient-Centered Specialty Practice

How Bassett Healthcare achieved PCSP recognition

From 1980 to 2000, the U.S. population grew by 23 percent, from an estimated 227 million to 279 million.[1] During the same period, the incidence of cancer rose 66 percent from 807,000 to 1.34 million.[1] Approximately 14 million people are currently "cancer survivors," with an expectation that this number will increase to 18 million by 2022;[1] the current estimate of 1.6 million cancer diagnoses per year is expected to rise to 2.3 million by 2030.[1] Of additional concern is the fact that the cost of cancer care is rising at a rate faster than other disciplines.[1] From 2004 to 2010, the cost of cancer care in this country rose dramatically from $72 billion to $125 billion.[1] This trend is expected to continue, with estimated costs growing 39 percent by 2020 to $173 billion.[1]

Uneasiness over our healthcare system's ability to provide care to this increasingly complex population has been steadily rising over the past decade. A model that fails to provide adequate transition of care can result in less than optimal outcomes and wasteful spending.[2] In 2011 avoidable medical complications and hospital readmissions cost the U.S. between $25 billion and $45 billion of unnecessary expenditures.[2]

Taken together, it has become clear that the U.S. healthcare model as we know it is simply unsustainable.

In its publication, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (IOM) states that patient care should be safe, effective, evidence-based, patient-centered, timely, efficient, and equitable.[3] The IOM report notes that patients who leave one care setting for another often receive minimal information with regard to medications, self-care, and whom to seek out for answers to questions.[3] Further, the IOM developed 13 recommendations for improving the delivery of healthcare in this country (see Table 1, pages 35-36).

In 2010 the American College of Physicians (ACP) endorsed the Patient-Centered Medical Home Neighbor (PCMH-N) concept, recognizing that to attain a comprehensive, coordinated model of care that meets the aims of the IOM report, there must be bi-directional communication between primary care physicians and their specialist counterparts.[4] This model of care is particularly relevant to patients with a cancer diagnosis, the advent of which can bring about great fear, anxiety, and uncertainty to a population presently receiving care in a system that is fragmented and not adequately structured to meet their needs.[1] Unfortunately, the complex nature of a cancer diagnosis encumbers treating physicians as they seek to provide accurate, evidence-based, and timely care, and often leaves patients with questions about their treatment plan, goals, and likelihood of survival.

Why PCSP Recognition?

Care coordination and communication between and among providers are among the core tenets of the National Committee for Quality Assurance's (NCQA's) evaluation program for specialty practices: Patient-Centered Specialty Practice (PCSP). The program is designed to formalize processes that are often already in place. PCSP sets standards and provides accountability for those caring for our patients—from front-line staff to physicians, in both the specialty and primary care practices. PCSP intends to reduce dissatisfaction among patients due to incomplete communication and fragmented care, as well as to reduce waste and improve outcomes.[5] These reductions are accomplished through:[5]

- Agreements between caregivers—both formal and informal
- Standards and guidelines for referrals, including expectations of the referring and receiving providers
- Information about the care team and defined quality improvement measures.

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Though PCSP is proven to generate cost savings, providers are not always interested in pursuing a new model of care.[2] Pursuing institutional approval and provider buy-in to seek PCSP recognition fosters conversation about an enhanced model of care that is a sound structural fit with oncology practices and many aspects of healthcare reform. Additionally, it provides an opportunity to analyze an oncology practice and determine ways to improve patient care.

PCSP Goals

As noted earlier, the goals of the PCSP are, ultimately, to enhance communication and coordination of care, resulting in increased patient satisfaction, reduced waste, and improved outcomes. In many ways, the objectives are aligned with the American College of Surgeons Commission on Cancer (CoC) patient-centered standards, particularly those that were phased in this year—psychosocial distress screening, patient navigation, and survivorship care planning.

Oncology practices that have implemented PCSP standards have reported increased efficiency in their practices, fewer ER visits and hospital admissions, and a decreased length of stay.[1] Enhanced efficiency is obtained by ensuring each staff member works to the highest level of his or her competency, as well as licensure. Additionally, increased care coordination results in less duplication of services, which adds to increased clinical effectiveness and reduction in unnecessary costs.

PCSP: The Next Stage of Continuous Improvement at Bassett Healthcare

In 2014, despite being part of an integrated network accredited by The Joint Commission and the CoC, Bassett Healthcare recognized that care coordination among and between its physician groups was not optimal. Our referring physicians were very pleased with the care their patients were getting at Bassett Cancer Institute; they just wanted more information. For example, one physician shared what happened when he did not know that a long-time patient had recently succumbed to his cancer. After running into the patient's wife in the local grocery store, the physician asked the woman how her husband was doing and was embarrassed to learn that he had recently passed away.

According to the NCQA, primary care providers (PCPs) report sending patient information to specialists 70 percent of the time; specialists report receiving the information only 35 percent of the time.[5] Conversely, specialists report sending a report to the PCP 81 percent of the time, whereas PCPs report receiving it only 62 percent of the time.[5] Additionally, between 25 to 50 percent of referring physicians did not know if their patients had seen a specialist.[5] Clearly this communication gap is problematic for the providers and leaves patients vulnerable.

Patients, too, expressed their frustration to us, *"It would have been nice to have someone help me through the system, most of which I did on my own. I am a doctor. I have worked in this hospital for many years. I know who to call…but I am not the doctor and don't want to be. I want to be a patient."*

Another patient stated, *"I felt that communication often got lost…I traveled from one department to another with no one looking at all aspects of my care. This lack of continuity often caused me more angst than the actual diagnosis."*

Many of our primary care practices are certified Patient-Centered Medical Homes and have had great success in better managing their patients' care. With their success for inspiration and a shared vision for communication, Bassett Healthcare decided to pursue early adoption of the Patient-Centered Specialty Practice, with the goal of better care coordination and increased patient satisfaction.

Attaining & Sustaining the PCSP Model of Care

There are six standards in the PCSP application, each with its own elements—approximately 22 in total (see Table 2, page 37). Among these elements are "must pass" standards. If a practice cannot adequately demonstrate that it meets these critical elements within the domain, no credit is granted. There are a total of 100 points, and recognition may be granted with as few as 25 points. Of importance, policies and procedures that are created to meet these standards must be in place three months before a PCSP application is submitted. Therefore, we strongly advise careful review and consideration of the application in advance. While Bassett Cancer Institute's application results were strong, they clearly identified areas we could focus on for additional quality improvement (QI) efforts. We share our results below.

PCSP 1: Track & Coordinate Referrals

(20/22 Points)

A key feature of the Patient-Centered Specialty Practice is the concept of a "neighborhood"—that is, ensuring a smooth transition of care from the primary care provider to the specialist. At the Bassett Cancer Institute, our team developed a referring provider agreement with a select group of primary care practices

as a pilot for receiving PCSP recognition. The agreement clearly outlines the reason for the referral (consult, second opinion, transfer of care) and the urgency of the referral. Essentially, the neighborhood is a commitment between the primary care physician and the specialist to work together to provide evidence-based, safe, effective, and coordinated care to patients.

To meet this element we strongly urge programs to *leverage their electronic health record* (EHR)! Our practice provides patients with a care plan prior to their treatment and prints an after-visit summary, which details the care provided. Our information technology (IT) team amended the EHR specialty referral form to allow options—second opinion, consult, care during treatment, or full assumption of care. Additionally, our referral has a free-form text field so that a referring clinician can offer additional information, as warranted.

PCSP 2: Provide Access & Communication

(9/18 Points)

In our practice, we have a clinician (usually a physician) who is identified as the "doctor of the day." Each provider (via a rotating daily schedule) is responsible for taking add-ons and urgent referrals, answering questions, and speaking to patients who may call or stop in, in addition to his or her full clinic schedule.

As a performance improvement project, our team developed a new patient handbook that clearly delineates the roles of our specialists, the availability of interpreter services, social work, dietary services, etc. Additionally, we enhanced Bassett Cancer Institute's website to ensure patients had access to information about their diagnosis and educational websites.

Despite having these processes in place, our surveyor stated we did not sufficiently document that patients received same-day appointments, timely clinical advice after hours, and non-visit consultations with referring clinicians. These are areas that we will continue to address through QI initiatives.

PCSP 3: Identify & Coordinate Patient Populations

(7/10 Points)

Many of the requirements in this element are captured in demographic information and/or Meaningful Use measures. Practices that are not yet in Meaningful Use-Stage 2 (we were not at the time) may struggle with certain aspects of this measure, namely generating a list of patients and providing a "proactive" reminder of caring for a healthcare condition. The condition does not necessarily need to be oncology specific, but is, in fact, more focused on primary care.

PCSP 4: Plan & Manage Care

(17/18 Points)

Our team identified a variety of resources to help us meet this measure, most of which are common in oncology practices.

Members of the Bassett Healthcare team that worked to achieve Patient-Centered Specialty Practice recognition. (L to R) Robin Abbass, RT(T), manager, Radiation Oncology; Bertine McKenna, PhD, chief operating officer and executive vice-president; Frank Panzarella, FACHE, vice president, Operations; James Leonardo, MD, PhD, division chief, Medical Oncology; Sue van der Sommen, FACHE, administrative director; Christine Conkling, medical oncology and community outreach manager; Kelly Morris, RN, OCN, nurse manager; and Tom Manion, director, Musculoskeletal Services (formerly the practice and business manager at the cancer center).

These resources include our psychosocial needs assessment, chemo education packet, and patient fund assistance applications, as well as examples of sharing information through our EHR.

PCSP 5: Track & Coordinate Care

(3/16 Points)

Clearly, we fell short in this area, despite it being a key success factor in the "medical neighborhood." Some of the elements included tracking secondary referrals, which are defined as referrals generated when an oncologist refers a patient to another specialist. Additionally, our oncologists do not have referral agreements with specialists to whom they refer. Having these agreements in place would be an added benefit to our patients. For continuity of care, this referral information must be provided to the primary care physician. In our present practice, it is not. This definitely represents an area targeted for improvement.

Another aspect of care is the long-sought after "care transition" model. We could not effectively demonstrate a process for tracking our patients when they go to the emergency department (ED) or are admitted to the hospital. Although we often know this information—it is the inherent nature of an oncology practice to know

the status of its patients—we do not have a formal process for effectively tracking this information.

Recognizing these gaps in our care model and the value that enhanced care coordination will add to our practice, our senior leaders recently approved a nurse navigator position. We are confident that the addition of a skilled navigator will assist our team in improving our patients' experience. Again, this highlights how the pursuit of the Patient-Centered Specialty Practice model can assist cancer administrators and practitioners in identifying opportunities for improvement and seeking solutions to improve the patient experience. If you apply for PCSP recognition and have a plan to hire a navigator in the future, be sure to include that information in the application.

PCSP 6: Measure & Improve Performance

(12/16 Points)

This element is largely focused on performance improvement, patient and family engagement, and setting goals to improve access to care. Bassett Cancer Institute uses Press Ganey to assess our overall patient satisfaction levels. Since clinician-specific scores are available, we share this information with our providers. In addition, our oncology team hosts patient focus groups to understand how our patients feel about our program—from our new patient handbook to the colors in our waiting area.

For programs interested in achieving PCSP recognition, this element provides an opportunity to leverage CoC standards 4.7 and 4.8: Studies of Quality.

We have found that coordinating improvement initiatives with our primary care colleagues is an area that requires further attention.

Leverage Existing Structures & Accreditations

Oncology practices are well suited for the PCSP model, particularly those that participate in CoC accreditation, QOPI (or other performance improvement initiatives), NAPBC, and/or Meaningful Use—which is a key component of PCSP measurement. Many components from these various accreditations and recognitions can be cross-walked with the PCSP scoring model, including, but not necessarily limited to, patient navigation, survivorship, and psychosocial distress screening.

Patient Focus, Measurable Results

The ultimate goal, of course, is always to provide exceptional, evidence-based care for our patient population by partnering with patients and referring providers. Additionally, the PCSP care model will better position oncology practices for health-care reform and to meet the challenges of the Institute for Healthcare Improvement's triple aim—improving the patient experience, enhancing the health of the population, and reducing the costs of care. OI

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Our Program At-a-Glance

Bassett Healthcare Network is an integrated healthcare system spanning over 5,600 square miles throughout an eight-county region in rural upstate New York. The network includes six affiliated hospitals and over 40 community and school-based health centers. Bassett Medical Center, the network's flagship site, is located in Cooperstown, N.Y., overlooking beautiful Otsego Lake.

Bassett Cancer Institute is a comprehensive community cancer center comprised of medical oncology, an ACRO-accredited radiation oncology department, and hematology. Having been continuously accredited by the CoC since 1947, it is one of the longest-standing accredited cancer centers in the country, and most recently achieved Gold Status.

Bassett Cancer Institute includes five infusion centers and two linear accelerators, with 1,244 accessioned cases in 2013. The cancer institute also provides screening services via a mobile medical coach, which, in July of 2014, received the Community Health Improvement Award from the Healthcare Association of New York State.

Table 1. IOM Recommendations for Improving Healthcare Delivery in the U.S.[3]

Recommendation 1	All healthcare organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.
Recommendation 2	All healthcare organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, healthcare should be safe, effective, patient-centered, timely, efficient, and equitable.
Recommendation 3	Congress should continue to authorize and appropriate funds for, and the Department of Health and Human Services should move forward expeditiously with the establishment of, monitoring and tracking processes for use in evaluating the progress of the health system in pursuit of the above-cited aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The Secretary of the Department of Health and Human Services should report annually to Congress and the President on the quality of care provided to the American people.
Recommendation 4	Private and public purchasers, healthcare organizations, clinicians, and patients should work together to redesign healthcare processes in accordance with the following rules: 1. Care based on continuous healing relationships 2. Customization based on patient needs and values 3. The patient as the source of control 4. Shared knowledge and the free flow of information 5. Evidence-based decision making 6. Safety as a system property 7. The need for transparency 8. Anticipation of needs 9. Continuous decrease in waste 10. Cooperation among clinicians.
Recommendation 5	The Agency for Healthcare Research and Quality (AHRQ) should identify not fewer than 15 priority conditions, taking into account frequency of occurrence, health burden, and resource use. In collaboration with the National Quality Forum (NQF), the agency should convene stakeholders, including purchasers, consumers, healthcare organizations, professional groups, and others, to develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years for each of the priority conditions.
Recommendation 6	Congress should establish a Healthcare Quality Innovation Fund to support projects targeted at: 1. Achieving the six aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity; and/or 2. Producing substantial improvements in quality for the priority conditions. The fund's resources should be invested in projects that will produce a public-domain portfolio of programs, tools, and technologies of widespread applicability.
Recommendation 7	AHRQ and private foundations should convene a series of workshops involving representatives from healthcare and other industries and the research community to identify, adapt, and implement state-of-the-art approaches to addressing the following challenges: • Redesign of care processes based on best practices • Use of information technologies to improve access to clinical information and support clinical decision making • Knowledge and skills management • Development of effective teams • Coordination of care across patient conditions, services, and settings over time • Incorporation of performance and outcome measurements for improvement and accountability. (*continued on page* 36)

Table 1. IOM Recommendations for Improving Healthcare Delivery in the U.S.[3] *(continued)*

Recommendation 8	The Secretary of the Department of Health and Human Services should be given the responsibility and necessary resources to establish and maintain a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients. In developing this program, the Secretary should work with federal agencies and in collaboration with professional and healthcare associations, the academic and research communities, and the NQF and other organizations involved in quality measurement and accountability.
Recommendation 9	Congress, the executive branch, leaders of healthcare organizations, public and private purchasers, and health informatics associations and vendors should make a renewed national commitment to building an information infrastructure to support healthcare delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade.
Recommendation 10	Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.
Recommendation 11	The Health Care Financing Administration (HCFA) and AHRQ, with input from private payers, healthcare organizations, and clinicians, should develop a research agenda to identify, pilot test, and evaluate various options for better aligning current payment methods with quality improvement goals.
Recommendation 12	A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for: 1. Restructuring clinical education to be consistent with the principles of the 21st Century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and 2. Assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.
Recommendation 13	The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems: 1. Facilitate or inhibit the changes needed for the 21st Century healthcare delivery system, and 2. Can be modified to support healthcare professionals and organizations that seek to accomplish the 6 aims set forth in Chapter 2.

Table 2. PCSP Recognition: 6 Standards, 22 Elements[5]

1. Track & Coordinate Referrals (22 pts)	*A. Referral process and agreements B. Referral content *C. Referral response
2. Provide Access & Communication (18 pts)	A. Access B. Electronic access C. Specialty practice responsibilities D. Culturally and linguistically appropriate services (CLAS) *E. The practice team
3. Identify & Coordinate Patient Populations (10 pts)	A. Patient information B. Clinical data C. Coordinate patient populations
4. Plan & Manage Care (18 pts)	A. Care planning and support self-care *B. Medication management C. Use of electronic prescribing
5. Track & Coordinate Care (16 pts)	A. Test tracking and follow-up B. Referral tracking and follow-up C. Coordinate care transitions
6. Measure & Improve Performance (16 pts)	A. Measure performance B. Measure patient and family experience *C. Implement and demonstrate continuous quality improvement D. Report performance E. Use of certified EHR technology

Recognition starts with 25 points. *Indicates "must pass" elements.