

**To Infinity and Beyond:  
Next Steps in the Development of a  
Systematic Approach to High Quality  
Family Centered Care within Florida's  
Early Steps System**

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### Objectives for Today's Meeting

- Understand rationale for NCQA's PCMH recognition program and requirements for practices to demonstrate the patient-centered medical home model and review information about quality, cost savings and pay-for-recognition initiatives
- Participants will learn the components of Plan-Do-Study Act Cycles within practice
- Participants will participate in discussion related to statewide priorities related to family centered practice -including discussion of measures

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### What is PCMH?

- A model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.
- Essential elements of this model of care include:
  - Improved Access,
  - Coordinated & Comprehensive Care based upon development of effective working relationships
  - Within a high performance culture, which embraces continuous improvement.

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### Why do it?

- Improve **access** to increase **patient satisfaction**, re: **service delivery**
- Improve **clinical outcomes** using **evidence-based** practice and health information technologies
- Prepare for and implement **new reimbursement methods**
- Create a **productive work environment** through committed teamwork, engaged leadership and effective communication
- Nurture a **high-performance culture** that encourages **innovation**, embraces **quality** and effectively manages **change**





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### Positive Impact on Practices

- Better care management programs
- Greater attention to patient compliance
- Improved patient outreach (patient reminders, increased screenings, educational materials)
- Increased data collection and reporting
- Significant adoption of patient registries





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*“trying to change the patterns of traditional practice (interventions/procedures /medications) is not as cost-effective as improving communication”*

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## Who uses PCMH Model?

- Most widely used tool in PCMH demonstrations with payment reform (Bitton et al 2010)
- Endorsed for Recognition by American Academy of Pediatrics, National Quality Forum, et al.
- Federal initiatives (CMS, HRSA, Military)
- State initiatives (NYS Medicaid, multi-payor efforts that include Medicaid in VT, RI, CO, ME, and more )




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## Of the >3500 Recognized Practices

- 15% are pediatrics only, >30% serve children
- 38% have only 1-2 physicians
- 60% are Level 3
- 48 states & DC have recognized practices (91 in FL, 85 Level 3)
- EMR is *not* required to achieve recognition
  - Level 1 recognition is achievable without EMR
  - Higher levels require more health IT




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## Initiatives Supporting NCQA Recognition Programs

- National/Multi-state – CMS, HRSA, MHS, Anthem, Aetna,
- Maine – Patient Centered Medical Home Pilot
- Vermont – Vermont “Blueprint for Health”
- North Carolina – Community Care of North Carolina (N3CN), BCBSNC
- Pennsylvania – Chronic Care Commission, PAFP
- Rhode Island – Rhode Island Quality Institute
- Minnesota – Primary Care Coordination Program – Facilitated by Office of the Commissioner of Securities and Insurance
- Maryland – Maryland Health Care Collaborative (MHCC)
- Michigan – Priority Health, Health Plan of Michigan and Medicaid Health Plan
- Massachusetts – State Medicaid PCMH Initiative
- New York – Adirondack Medical Home Demonstration , State Medicaid
- Ohio – Cincinnati Health Improvement Collaborative
- Colorado – Colorado Clinical Guidelines Collaborative
- Louisiana – Through DHH the Louisiana Health Care Quality Forum
- Florida – BCBSFL Care Management and P4P Quality Initiative
- Connecticut - Connecticut Department of Social Services– Medicaid Initiative




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## Background Origin of the Demonstration Project

February 2009  
President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA)

September 2009  
CMS issued a Request for Proposal

January 2010  
Florida & Illinois submitted joint proposal

February 2010  
Florida & Illinois awarded CHIPRA grant

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## Florida's Medical Home Project

- 20 pilot practices
- Structured approach including
  - Practice self assessment, planning and implementation of change, measurement, adjustment, re-measure...based upon quality indicators of PCMH
  - Technical Assistance from AAP and UF

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High Performance Practice Team  
Anticipates needs of the Patient

Continuous Care  
Patient Centered Care

Established Access  
Prevention Based Care  
Coordinated Care  
Comprehensive Patient Care

Patient / Family  
Source of Control

Health Information Technology (HIT)  
Comprehensive Payment

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## Federal Approach to Process

- A. Measure and report on child health quality
- B. Coordinate child health quality reporting with new health information system development
- **C. Test (or enhance) provider-based models to improve primary care delivery**
- D. Develop and test a pediatric electronic health record
- E. Create other means of improving child health care quality, access, or delivery




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## Paradigm Shift

- From Individual to **Population**
- From Physician (Provider) to **Team-Based**
- From Episodic to **Continuous** care
- From Episodic payment to **Comprehensive payment**
- From Clinician Centered to **Patient Centered**




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## PCMH Scoring

6 standards = 100 points  
6 Must Pass elements

**NOTE:** Must Pass elements require a  $\geq 50\%$  performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 "Must Pass" Elements are not Recognized.




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## 2011 PCMH Content and Scoring

Standard	Element	Pts	Standard	Element	Pts		
Standard 1: Enhance Access and Continuity	A. Access During Office Hours**	4	Standard 4: Provide Self-Care Support and Community Resources	A. Support Self-Care Process**	6		
	B. After-Hours Access	4		B. Provide Referrals to Community Resources	3		
	C. Electronic Access	2	Standard 5: Track and Coordinate Care		Pts		
	D. Continuity	2					
	E. Medical Home Responsibilities	2					
	F. Culturally and Linguistically Appropriate Services	4					
	G. Practice Team	20					
Standard 2: Identify and Manage Patient Populations	A. Patient Information	3	Standard 6: Measure and Improve Performance		Pts		
	B. Clinical Data	4					
	C. Comprehensive Health Assessment	5					
	D. Use Data for Population Management**	16					
Standard 3: Plan and Manage Care	A. Implement Evidence-Based Guidelines	4				A. Measure Performance	4
	B. Identify High-Risk Patients	4				B. Measure Patient/Family Experience	4
	C. Care Management**	3				C. Implement Continuously Quality Improvement**	3
	D. Medication Management	3	D. Demonstrate Continuous Quality Improvement	2			
	E. Use Electronic Prescribing	7	E. Report Performance	2			
			F. Report Data Externally	0			
			G. Use of Certified EHR Technology	20			

Must Pass Elements




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## Must Pass Elements

- Rationale for Must Pass Elements**
- Identifies critical concepts of PCMH
  - Helps focus Level 1 practices on most important aspects of PCMH
  - Guides practices in PCMH evolution and continuous quality improvement
  - Standardizes "Recognition"
- Must Pass Elements**
- 1A: Access During Office Hours
  - 2D: Use Data for Population Management
  - 3C: Manage Care
  - 4A: Self-Care Process
  - 5B: Referral Tracking and Follow-Up
  - 6C: Implement Continuous Quality Improvement




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## NCQA Survey Process Components

- Standards and Elements** – basis for scoring, each described with type of documentation required and level of health information technology required
- Important conditions** – basis for data responses in multiple elements
- Survey Tool** – software to record and score practice responses and file documentation
- Record Review Workbook** - requires data from selected medical records
- Documentation** – identify and organize documents needed for evidence of compliance with each element
- Readiness** – practice uses the Survey Tool to assess readiness to meet the standards and submit




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## Overview of NCQA Recognition Process

- Review requires Survey Tool, application information: NCQA Agreement and Business Associate Addendum (BAA), Application, Clinician Information
- Licensure check of all clinicians
- Evaluation includes Survey Tool responses, documentation, and explanations by trained reviewers
- 5% audit by email, teleconference, or on site visit
- Executive review by NCQA for consistency
- Peer review by trained Review Oversight Committee (ROC) member
- Final decision and status to the practice within 30 – 60 days
- Results reported - Recognition posted on NCQA Web site and distributed on monthly data feeds
- Recognition packet provided - Certificate, press release and advertising guidelines



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## NCQA Recognition levels

- Allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows.
  - **Level 1:** 35–59 points and all 6 must-pass elements
  - **Level 2:** 60–84 points and all 6 must-pass elements
  - **Level 3:** 85–100 points and all 6 must-pass elements

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## Best Practices: What We Have Learned

- Roadmap for quality improvement
- Recognizes roles of every care team member, physicians and mid-level practitioners
- Coordinated teamwork
- Patient/family engagement
- Enables practice system change
- Share benefits with patients and payors
- Connection to community resources



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## NCQA Contact Information

**Contact NCQA Customer Support to:**

- Acquire standards documents, application materials, and survey tools
- Questions about your user ID, password, access
- 1-888-275-7585

**Visit NCQA Web Site to:**

- View Frequently Asked Questions
- View Recognition Programs Training Schedule

Submit to questions to [pcmh@ncqa.org](mailto:pcmh@ncqa.org)

**Or direct questions to your assigned team contacts:**

- Ask about interpretation of standards or elements
- Request technical assistance with the application process




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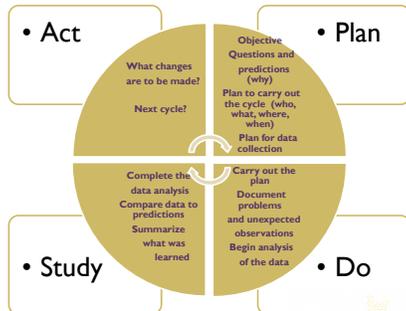
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## PDSA Process




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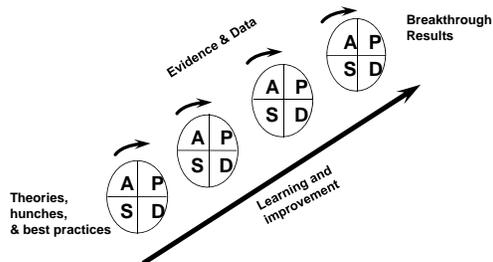
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## PDSA Cycles




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## Medical Home Index

Domains	Themes
1. Organizational capacity	1.1 Mission of the practice 1.2 Communication/access 1.3 Access to medical records 1.4 Office environment 1.5 Family feedback 1.6 Cultural competence 1.7 Staff education
2. Chronic condition management	2.1 Identification of CSHCN 2.2 Care continuity 2.3 Continuity across settings 2.4 Cooperative management with specialists 2.5 Supporting transition to adult services
3. Care coordination	2.6 Family support 3.1 Role definition 3.2 Family involvement 3.3 Child and family education 3.4 Assessment of needs/plans of care 3.5 Resource information and referrals 3.6 Advocacy
4. Community outreach	4.1 Community assessment of needs of CSHCN 4.2 Community outreach to agencies and schools
5. Data management	5.1 Electronic data support 5.2 Data retrieval capacity
6. Quality improvement	6.1 Quality standards (structures) 6.2 Quality activities (processes)

early steps  
Children's Medical Services

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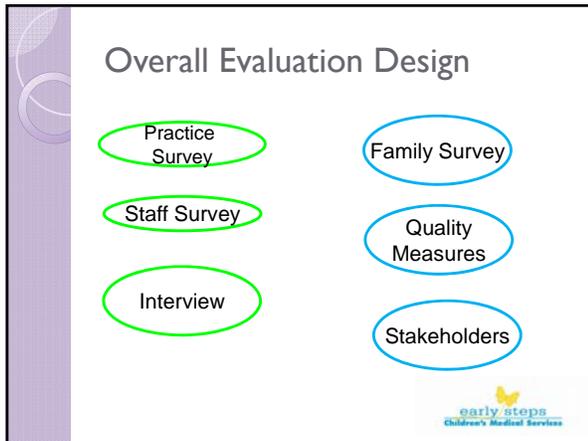
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- ## Quality Measures
- Prevention/Health Promotion
  - Management of Acute Illness
  - Management of Chronic Illness
  - Patient Experience
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Buzz Words....



**Communication**



**Problem Solving**

**Teamwork**




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Where we are:

- We have family resource specialist system in place across state
- We have data reporting requirements built in to system (current issues with Med 3000 notwithstanding) 🤖
- We have some benchmarks developed – especially related to processes

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**Next Steps:**

- Introduce the culture of change
- Identify local practices willing to pilot change
- Establish an Interdisciplinary team led by a champion in each practice, LES and ESSO who will be responsible to implement and monitor the changes
- Train and educate providers and staff
- Observe program and practice flow from the family perspective to evaluate the gaps

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**Next Steps:**  
**Potential Financial Impact**

- Identify Group to Champion to Medicaid
- Approach BCBS, which has already done this for Medical Practices

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**What is up front cost to ESSO, LES & Providers?**

- Training Cost
- Development of Quality Self Reporting format online for PDSA activities
- Cost of additional reporting requirements (EMR upgrades)

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**Early Steps Crosswalk to PCMH Elements**

**Standard 1: Enhance Access and Continuity**

- A. **Access During Office Hours\*\***
- B. After-Hours Access
- C. Electronic Access
- D. Continuity
- E. Medical Home Responsibilities
- F. Culturally and Linguistically Appropriate Services
- G. Practice Team

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- The practice provides electronic access
- Patients may select a clinician
- The focus is on team-based care with trained staff

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**EARLY STEPS**

- A. Access to Timely Services
- B. Continuity: SC stability; Team Member Stability
- C. Electronic Access for Families to Care Information
- D. Culturally and Linguistically Appropriate Services
- E. Practice Team

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**Early Steps Crosswalk to PCMH Elements**

**Standard 2: Identify and Manage Patient Populations**

- A. Patient Information
- B. Clinical Data
- C. Comprehensive Health Assessment
- D. **Use Data for Population Management\*\***

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

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## Early Steps

- A. Patient information: demographic/insurance/family constellation/communication preferences
- B. Clinical Data: IFSP development, progress monitoring
- C. Comprehensive Assessment: Needs and Strengths Assessment
- D. Population based management: pro-active reminders related to IFSP meetings, transition, other risk factors (all children with ASD are identified so that parent support activities specific to their needs can be forwarded to them/all children in foster care are identified and screened for trauma)

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## Early Steps Crosswalk to PCMH Elements

**Standard 3: Plan and Manage Care**

<ul style="list-style-type: none"> <li>A. Implement Evidence-Based Guidelines</li> <li>B. Identify High-Risk Patients</li> <li>C. <b>Care Management**</b></li> <li>D. Medication Management</li> <li>E. Use Electronic Prescribing</li> </ul>	<ul style="list-style-type: none"> <li>• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems</li> <li>• Care management emphasizes:             <ul style="list-style-type: none"> <li>◦ Pre-visit planning</li> <li>◦ Assessing patient progress toward treatment goals</li> <li>◦ Addressing patient barriers to treatment goals</li> </ul> </li> <li>• The practice reconciles patient medications at visits and post-hospitalization</li> <li>• The practice uses e-prescribing</li> </ul>
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## Early Steps Crosswalk to PCMH Elements

- A. Evidence Based Guidelines
  - Practice has documented procedures that cite evidence based guidelines
- B. Identify High Risk Patients (Child Abuse, parental mental health disorders, DV, Medically Complex)
- C. Care Management =Service Coordination
- D. Electronic IFSP, development of communication systems between LES and EI providers, LES and Other systems of care

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**Early Steps Crosswalk to PCMH Elements**

**Standard 4: Provide Self-Care Support and Community Resources**

A. Support Self-Care Process\*\*  
 B. Provide Referrals to Community Resources

- 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
- Practice clinicians counsel patients on healthy behaviors
- The practice assesses and provides or arranges for mental health/substance abuse treatment

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**Early Steps Crosswalk to PCMH Elements**

- The practice assesses patient/family self-management abilities – IFSP addresses family concerns, strengths/needs. Some of goals should address family/caregiver skills
- The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources - IFSP
- Practice clinicians counsel patients on healthy behaviors – translate to healthy routines – activities of daily living (Natural Environments)
- The practice assesses and provides or arranges for mental health/substance abuse treatment: documentation of screening/resource-referral as part of IFSP process

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**Early Steps Crosswalk to PCMH Elements**

**Standard 5: Track and Coordinate Care**

A. Test Tracking and Follow-Up  
 B. Referral Tracking and Follow-Up\*\*  
 C. Coordinate with Facilities/Care Transitions

- The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
- The practice follows up with discharged patients

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**Early Steps Crosswalk to PCMH Elements**

- A. Test Tracking and Follow-Up
- B. Referral Tracking and Follow-Up\*\***
  - Practice tracks if referrals for consultation, audiology/vision testing, additional medical work up completed
- C. Coordinate with Facilities/Care Transitions
  - Transition Process

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**Early Steps Crosswalk to PCMH Elements**

**Standard 6: Measure and Improve Performance**

- A. Measure Performance
- B. Measure Patient/Family Experience
- C. Implement Continuously Quality Improvement\*\***
- D. Demonstrate Continuous Quality Improvement
- E. Report Performance Internally
- F. Report Data Externally
- G. Use of Certified EHR Technology

- 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

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**Early Steps Crosswalk to PCMH Elements**

- A. Measure Performance
  - Provider measures their own performance
- B. Measure Patient/Family Experience:
  - Family surveys/family advisory councils
- C. Implement Continuously Quality Improvement\*\***
- D. Demonstrate Continuous Quality Improvement
  - (Plan, do study, act cycles with run charts to show progress)
- E. Report Performance Internally and F. Report Data Externally
  - (Provider reports their performance to LES, internal meetings with staff)
- F. Use of Certified EHR Technology
  - Allows for report building related to demographics, tracking of timelines for IFSP reviews/transition

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**Integration of Standards**

- [PCMH 2011\\_Overview\\_5.2\[1\].pdf](#)

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**Medical Neighborhood**

- Definition: PCMH and the constellation of other clinicians providing health care services to patients within it, along with community and social service organizations and State and local public health agencies
- Emphasis on holding groups of providers jointly responsible for the costs and outcomes of care for a defined population of patients
- Not a geographic construct but instead a set of relationships revolving around the patient and his or her PCMH, based on that patient's health care needs

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**Features of High Functioning Neighborhood**

- Agreement on roles of neighbors –care coordination agreements between PCP's and specialists
  - Pre referral Arrangements
  - Referral and FU guidelines
  - Care Transitions
- Information Sharing: supports effective decision making, reduces duplication and waste-includes IT systems supports
- Care Teams: usually anchored by PCMH
  - Individualized Care Plans for complex patients
  - Proactive sequence of health care interventions and interactions
  - Tracking to ensure sequence is completed (including transition)

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## Features of High Functioning Neighborhood

- Continuity of needed care during transitions (I would argue during specialty care as well) including communication, collaboration, must include family/patient
- Focus on patient preferences during decision making – use of a care coordinator who is neutral. Balance of science and preference to make optimal decisions with patient
- Community linkages including clinical and non clinical services (home meals, respite, food bank etc.)

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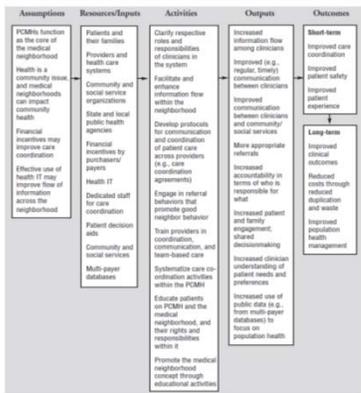
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Figure 2. Proposed logic model: outcomes of a well-functioning medical neighborhood




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## Take Home Message

- Team-work is vital
- Steal ideas *shamelessly* from peers & adapt to your practice
- Change takes time
- PDSA cycles - test on a small scale and see what works for your practice
- Everyone already has elements of a patient centered medical home!- goal is to move towards the ideal




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CHANGE TAKES TIME,  
EFFORT and TEAMWORK



How long do you think it took to build  
the Eiffel Tower ?

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Rewards: The Oscar Goes To...



early steps  
Children's Medical Services

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Time for Lunch: Let them eat  
cake...



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