Patient-Centered Medical Home (PCMH) & Patient-Centered Specialty Practice (PCSP)

Foundation for a Better Health Care System

Presenter
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Objectives:

• Definition and benefits of PCMH, PCSP and the medical neighborhood
• Review the challenges faced and the impact of successfully closing the care delivery loop
• Value-based payment structure and the PCMH, PCSP and medical neighborhood structure
**Definitions**

**Patient-Centered Medical Home (PCMH)**
A model of care that replaces episodic care based on illness and patient complaints with *coordinated, comprehensive long-term primary care* through a personal physician and an integrated healthcare team.

**Patient-Centered Specialty Practice (PCSP)**
A program that focuses on coordinating and sharing information among primary care clinicians and specialists. It requires clinicians to *organize care around patients*—across all clinicians seen by a patient—and to include patients and their families or other caregivers in planning care and as partners in managing conditions.

**Medical Neighborhood**

“The medical neighborhood is a set of principles and expectations, supported by the requisite systems and processes, to ensure coordinated and efficient care for all patients”

These are building blocks for clinical integration.
Patient-Centered Medical Home

PCMH is a care model that strengthens the clinician-patient relationship by

- Utilizing a team approach implemented with collaborative responsibility for patient care
- Continuous and quality improvements that are embedded in the practice culture
- Patients understanding their healthcare needs and participating in managing their care

A medical home is characterized by

- Continuous and open communication between patients and providers
- Use of enabled health information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance
- High levels of accessibility
Joint Principles for the Medical Home

• The joint principles of the “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs” were released in March 2007 by four organizations
  • American Academy of Family Physicians (AAFP)
  • American Academy of Pediatrics (AAP)
  • American College of Physicians (ACP)
  • American Osteopathic Association (AOA)

The seven foundational components embodied in these joint principles of PCMH are the following concepts:

✓ the personal physician
✓ a physician-directed, team-based approach to medical practice
✓ a whole-person orientation
✓ coordinated and integrated care
✓ quality and safety
✓ enhanced access
✓ appropriate payment framework
Recognition and Accreditation Organizations

There are four Medical Home Recognition and Accreditation Programs

1. National Committee for Quality Assurance (NCQA) 450*
2. URAC (formerly the Utilization Review Accreditation Commission) >5*
3. Joint Commission 50*
4. Accreditation Association for Ambulatory Health Care (AAAHC) >5*

* From the record of the Ohio Department of Health in August 2014
There are **two** NCQA medical home certifications - **PCMH and PCSP**

- **NCQA’s Patient-Centered Medical Home** standards - for primary care providers - first released in 2008
  - 2011 standards version published in 2011 ("PCMH 2011")
  - 2014 standards version published in 2014 (“PCMH 2014”)
  - 2017 standards version will be released in April 2017 (“PCMH 2017”)

- The NCQA 2011 PCMH standards align closely with using health information technology to improve quality and with meaningful use Stage 1 requirements. The 2014 Standards align with MU Stage 2. The 2017 Standards will align with MU Stage 3.

- **Two NCQA Medical Home Recognition Programs** NCQA’s **Patient-Centered Specialty Practice** (PCSP) program is for specialists and was released in 2013 and 2016.
Site Specific Recognition and Provider Eligibility

- NCQA recognition is granted to the **practice sites**, as well as the eligible providers practicing at those sites
  - Recognized providers are listed by name on the NCQA website

For both Patient Centered Medical Home (PCMH) AND Patient Centered Specialty Practice (PCSP) eligible providers include:
  - Primary Care Providers (MDs and DOs)
  - Nurse Practitioners (NPs)
  - Physician Assistants (PAs)

- For the Patient-Centered Specialty Practice (PCSP) besides physicians (MDs and DOs), NPs, and PAs, the following are also eligible:
  - Certified Nurse Midwives
  - Behavioral Health Specialists including
    - State Certified or Licensed Psychologists and Clinical Social Workers
    - Marriage and Family counselors registered or licensed by the state to practice independently
NCQA Provider-Based Quality Programs

ACO Accreditation

DRP & HSRP Recognition

PCMH & PCSP Recognition
Benefits of Practice Transformation

**Features** of a high performing PCMH practice:
- Dedicated care managers
- Expanded access
- Data-driven analytic tools
- Staff learn collaboratively
- Sharing of best practices
- Incentives

**Benefits** may include:
- Improved patient experience
- Reduced clinician burnout
- Reduced hospitalization rates
- Reduced ER visits
- Increased savings per patient
- Higher quality of care
- Reduced cost of care

Numerous payers in the state offer incentive payments to providers who meet the NCQA criteria.
Intent of the Triple Aim

• Improve the patient experience of care including quality and satisfaction
• Improve the health of populations
• Reduce the per-capita cost of healthcare

Institute of Health Care Improvement (IHI)
PCMH, Medical Neighborhoods, and the Triple Quadruple Aim

IHI’s Quadruple Aim

Benefits:
- Improving health of population
- Reduced readmission
- Reduces error related complications

Benefits:
- Improving the patient’s experience of care
- Less patient suffering through reduced Medical Errors, HAIs and injuries
- Quality and satisfaction

Benefits:
- Improving the Care of and Experience of the Health Care Professionals
- Improves employee satisfaction and turnover, improves patient satisfaction and reduces workplace injuries

Benefits:
- Improving the patient’s experience of care
- Less patient suffering through reduced Medical Errors, HAIs and injuries
- Quality and satisfaction

Benefits:
- Improving Provider Work Life
- Improves employee satisfaction and turnover, improves patient satisfaction and reduces workplace injuries

Benefits:
- Reducing the per capita cost of health care
- Reduced spending for Worker’s Compensation Claims, Medical Error litigation, lost productivity, reduced readmission expense

Industry Trends in Focus

• Triple Aim: Improve Cost, Quality, Patient Experience
• Population health management
• Integrated Care
• Care transitions and self-care support
• Movement towards a value-based model.
What is the Problem?

**Poor Integration**
- Leakage of patients and patient information leads to inability to coordinate care effectively as well as loss of revenue.

**Inefficiency**
- Different workflow for each specialty leads to confusion, poor service
- Low satisfaction among referring PCPs

**Access**
- Lack of triage leads to inefficient access, with timing of appointment not tied to urgency of need

**Tracking**
- No ability to track referrals and use for business intelligence and workflow improvement
Poor Integration

Primary Care in Not Enough
The Importance of Care Coordination

• The typical PCP needs to coordinate care with 229 other physicians working in 117 practices. (*Pham et. al., Ann Int Med. 2009*)

• In the Medicare population, the average beneficiary sees seven different physicians and fills upwards of 20 prescriptions per year. (*Partnership for Solutions, Johns Hopkins Univ. 2002*)

• Among the elderly, on average two referrals are made per person per year. (*Shea et al. Health Service Research, 1999*)

• In the nonelderly population, about one-third of patients each year is referred to a specialist. (*Forrest, Majeed, et al. BMJ 2002*)

• Visits to specialists constitute more than half of outpatient physician visits in the United States. (*Machlin and Carper, AHRQ, 2007*)
Evidence of Dysfunction

- 25-50% of referring physicians did not know whether their patients had actually seen the specialist to which they were referred.
- PCPs report sending a history or reason for a specialist consult 70% of the time but specialists report receiving such information only about 35% of the time.
- Specialists report sending consult notes and patient advice to PCPs 80% percent of the time, PCPs report receiving such information 62% of the time.

Key Aims of PCMH-PCSP

- Patient Access (timely appointments and advice)
- Agreements with PCP to coordinate care
- Timely (information exchange with PCP)
- Timely referral summary to referring physician
- Care Plan coordination with PCP
- Communication with patient and PCP
- Reduced duplication of tests
- Measure Performance
- Align with Meaningful use of EMR
Care Integration and Coordination are Key Considerations

- Patient-Centered Specialty Practice (PCSP)
  - Improved patient access
  - Team-based care
  - QI infrastructure
  - Proactive Outreach/Care Management
  - Enhanced coordination with referring providers
  - Accommodates the range of relationships between PCP and Specialist:
    1. Consulting on patients
    2. Evaluating and treating patients
    3. Co-managing patients
    4. Providing temporary/permanent care management for some patients

Patient-Centered Connected Care (PCCC)
PCMH Primary Care and PCSP Specialty Care

**PCMH Primary Care**
- Whole-person care
- First contact for most problems
- Clinician leads a care team
- Comprehensive, coordinated care
- Continuous care
- Focus on population, individual care

**PCSP Specialty Care**
- Comprehensive for single disease
- Usually not first contact
- Coordinates with primary care
- Continuous care for active disease
- Specialty-focused population, individual care
Collaborative Care Agreement

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<tr>
<th></th>
<th>Referring physician agrees to…</th>
<th>Receiving physicians agrees to …</th>
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<tbody>
<tr>
<td><strong>Pre-consult Exchange</strong></td>
<td>• State clinical question</td>
<td>• Respond to requests within specified time</td>
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<td></td>
<td>• Use agreed-upon modality</td>
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<tr>
<td><strong>Formal Consultation</strong></td>
<td>• Request referral and state reason</td>
<td></td>
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<tr>
<td></td>
<td>• Order appropriate tests</td>
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<tr>
<td></td>
<td>• Refer to specialists</td>
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<tr>
<td><strong>Co-management</strong></td>
<td>Both parties agree to…</td>
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<tr>
<td></td>
<td>• Agree on who manages medications, lab monitoring, etc</td>
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<td>• Notify each other of major interventions, ED visits, hospitalizations</td>
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<td>• Offer urgent visits to patients within 1-2 days</td>
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<td>• Confer with each other prior to ordering additional referrals related to condition</td>
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Challenges

• Unaccustomed to standardized evaluation
  • systems, including documented process and measures
• Unrealistic self-assessment
• Limited external incentives
• Unfamiliar with transformation or team-based care
• Potential for poor communication leading to frustration, wasted time with resultant decreased quality, safety and worse outcomes
• Staffing model has not been proven
  • Varies practice by practice, specialty by specialty
  • Procedures make presence in practice disjointed
  • Applying the primary care model does not work
• Lack of processes for clear patient attribution
• Many orders not made by the specialist directly
  • Many results do not feed directly back into EMR
• Sub-specialization makes practices non-uniform internally
• Quality measures not standardized in many fields
  • Most lack years of preparation for quality improvement
Strategies

Some of the prevention and management strategies:

• Population health approach
• Addressing social determinants
• Integration of medical and behavioral care
• Using interprofessional teams
• Learning about best practices
• Employer initiatives
Value to a Practice

• **Shows purchasers** (public, private, pilot program sponsors) that specialists are ready to participate in reforms

• **Activates** the American College of Physician’s “PCMH neighborhood”

• **Distinguishes practices** as committed to coordinating care and reducing waste

• **Potential incentives:**
  - Monthly coordinating payments to practices
  - Encourage PCPs to refer patients to NCQA-Recognized PCSP specialists
  - Public recognition-devotion to the Triple Aim
  - Use the recognition as a quality indicator in value-based purchasing initiatives (lower co-pays)
  - Entry requirement for new initiatives to benefit from shared savings
  - Recognition might allow a clinician to bypass administrative requirements (i.e. prior authorization).
  - Avoid penalties, realize bonuses through Medicare Access and CHIP Reauthorization ACT (MACRA)/Merit Based Incentive Payment System (MIPS)-“highest potential score for the performance category”

MACRA: Pub. L 114-10 Sec. 101(c) (April 16, 2015)
# Medical Neighborhood: Value in Any Payment Scheme

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<tr>
<th>Volume</th>
<th>Value</th>
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<tbody>
<tr>
<td>• Capture more referrals</td>
<td>• Better triage</td>
</tr>
<tr>
<td>• Reduce unneeded referrals improves access</td>
<td>→ Appropriateness</td>
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<tr>
<td>• Reduce leakage outside</td>
<td>• eConsults lead to</td>
</tr>
<tr>
<td>• Facilitate more referrals from affiliates</td>
<td>• Better triage and avoidance of unnecessary referrals through pre-referral communication</td>
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<tr>
<td>• Success under fee-for-service</td>
<td>• Potential for increased coordination for complex patients spanning multiple specialties</td>
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<td></td>
<td>• Success in risk-based contracts and fee-for-service</td>
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“...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 March 2012 Quality Awards
Let us make the pieces fit...
Thank you