Patient-Centered Specialty Practice (PCSP) Recognition Program

April 25, 2013
Key Points

• Recognizes specialists who meet high standards for care coordination
  – Builds on success of NCQA’s PCMH program

• Area of delivery system reform that promises to save money and improve quality

• Could be a component of an ACO, network or payment strategy
An Opportunity to Improve Care

- Poor communication leads to frustration and wasted time, and can lead to poor quality, safety and outcomes
  - PCPs report sending information 70% of the time; specialists report receiving the information 35% of the time\(^1\)
  - Specialists report sending a report 81% of the time; PCPs report receiving it 62% of the time\(^1\)
  - 25%-50% of referring physicians did not know if patients had seen a specialist\(^2\)

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The Importance of Coordinating Care

• The typical PCP has 229 other physicians working in 117 practices with which care must be coordinated (Pham, H.H. (2010). Good neighbors: How will the Patient-Centered Medical Home relate to the rest of the health-care delivery system? Journal of General Internal Medicine, 25 (6), 630-4.)

• 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 in three 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)
Value to Practices

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

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

• Better referrals: improves appropriateness & efficiency
The PCSP Design

- **Goal:** Enhance primary/specialist collaboration and coordination to benefit patients
- **Accommodates the range of relationships between PCP and specialist:**
  1. Consulting on patients
  2. Evaluating and treating patients
  3. Comanaging patients
  4. Providing temporary/permanent care management for some patients
- **Practices are likely to have patients in each “category”**
The PCSP Standards  
(6 standards/22 elements)

1. **Track & Coordinate Referrals (22)**
   A. Referral Process and Agreements*
   B. Referral Content
   C. Referral Response*

2. **Provide Access & Communication (18)**
   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)**
   A. Patient Information
   B. Clinical Data
   C. Coordinate Patient Populations

4. **Plan & Manage Care (18)**
   A. Care Planning and Support Self-Care
   B. Medication Management*
   C. Use Electronic Prescribing

5. **Track & Coordinate Care (16)**
   A. Test Tracking and Follow-Up
   B. Referral Tracking and Follow-Up
   C. Coordinate Care Transitions

6. **Measure & Improve Performance (16)**
   A. Measure Performance
   B. Measure Patient/Family Experience
   C. Implement and Demonstrate Continuous Quality Improvement*
   D. Report Performance
   E. Use Certified EHR Technology

*Must-Pass

Recognition starts with 25 points
Strategies for Using PCSP

- Encourage PCPs to refer patients to PCSP specialists
- Choose recognized specialty practices to participate in new delivery-system reform initiatives
- Recognition as a “gold card,” allowing clinicians to bypass requirements for prior authorization
- Recognition designation as a quality indicator in value-based purchasing initiatives; possibly “preferred tier” with lower co-pay
- Publish recognition status in clinician network directories and consumer/member Web sites
- Make care coordination payments available to recognized specialists