Overview

- Central challenge: Creating systems out of fragmentation
- Where it began: the Patient-Centered Medical Home (PCMH)
- Where we are now: the Patient-Centered Specialty Practice (PCSP)
- Oncology: a key focus
- Moving forward: building care coordination and management into payment
AHRQ Study on HIT & Care Coordination: Early Results

- Practices vary widely in care coordination workflows and use of EHR capabilities
- Barriers include staffing, workflow, low interoperability across HIT systems
- Meeting the ONC/CMS Meaningful Use objectives does not fully address important aspects of care coordination
- Care coordination requires significant, dedicated staff and resources
As of April 30, 2014 there were 36,915 clinicians in 7,338 sites.
Why engage specialists? An opportunity to improve care

Poor communication leads to frustration, waste, poor quality, safety & outcomes:

PCPs report sending information 70% of the time; specialists report receiving it 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\(^2\)


Patient-Centered Specialty Practice (PCSP) Recognition

- Complementary to PCMH Recognition
- Goal is to accredit “what should be” not “what is”
- Recognizes specialists for exemplary care coordination, communication
- Could be a component of an ACO, network or payment strategy
- Aligns with Meaningful Use
- First recognition awarded in February to Hematology / Oncology Practice
- Over 200 practices in pipeline
Even if individual organizations are high quality, effective **systems** require coordination…
1. **Track and Coordinate Referrals (22)**
   A. *Referral Process and Agreements*
   B. Referral Content
   C. *Referral Response*

2. **Provide Access and Communication (18)**
   A. Access
   B. Electronic Access
   C. Specialty Practice Responsibilities
   D. Culturally and Linguistically Appropriate Services (CLAS)
   E. *The Practice Team*

3. **Identify and Coordinate Patient Populations (10)**
   A. Patient Information
   B. Clinical Data
   C. Coordinate Patient Populations

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

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

6. **Measure and 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

Recognition starts with 25 points

*Must Pass
PCSP Accounts for Differences in Specialty Care Models

Model 1: Consultative / Procedural
- Accepts referral from PCP
- Provides discreet service
- Transfers patient back to PCP to continue care
- Example: Orthopedist performing ACL repair

Model 2: Co-Management
- Collaborates with PCP to deliver care
- Shares certain care management, care coordination functions with PCP
- Example: Cardiologist working with PCP to provide care to patient with Chronic Heart Failure

Model 3: Specialty Medical Home / Care Management
- Primary source of care for agreed-upon period of time
- Performs all care management, care coordination functions
- Example: Oncologist treating cancer patient
Patient-Centered Oncology Pilot & Evaluation

- **Patient-Centered Outcomes Research Institute (PCORI) three year contract**
- **Partners**: American Society for Clinical Oncology (ASCO), National Coalition for Cancer Survivorship (NCCS), Oncology Management Services (OMS), RAND Corporation (RAND), Independence Blue Cross (IBC)
- **Research aims**: understand transformation experience of oncology practices; evaluate the impact of a patient-centered oncology model on:
  - Quality of care
  - Patient experiences
  - Use of unplanned emergency and hospital care and of hospice care
How to build care coordination and management into payment reform

‘Doc Fix’
H.R. 4015 / S 1871
PC MH/PC SP eligible for chronic care management payment, credit in new P4P system
Medical homes can be Alternative Payment Models

Step 2
Shift measurement, incentives to practice level (vs. eligible provider)
Work for better outcomes-based assessments
Align across public & private-sector payers

Step 3
Move away from using fee-schedule
Support capitation and blended payment models
Encourage links to fully integrated systems (include LTSS, behavioral health)