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Beyond Primary Care: *Expanding the Medical Home to Cardiology*

The patient-centered medical home (PCMH) model is mainly applicable to primary care medicine. This care model is beginning to pique the interests of specialists across the country, including independent and employed cardiology groups. The primary objective of the PCMH model is to promote comprehensive, coordinated, and integrated care by using care teams to more effectively manage acute and chronic conditions and provide preventive services. This, in turn, keeps patients healthy and out of more costly care settings.

Even when a PCMH is able to reduce unnecessary specialty visits by better managing the health of a population, some patients will still require more costly specialty care, such as cardiovascular services. The management of cardiovascular conditions frequently involves complex care protocols and extensive multidisciplinary input. As a result, cardiologists often find themselves serving in a dual primary care/cardiology role. This places more responsibility on the cardiologist to find effective ways to ensure care coordination among all of the patient's core providers and to balance the level of medical management and procedural care needed for each cardiology patient's particular condition.

One approach gaining traction in the cardiology care arena is the specialist medical home model. In 2013, the National Committee for Quality Assurance (NCQA) launched the Patient-Centered Specialty Practice (PCSP) Recognition program, which is aimed at aligning specialty care models, including cardiology, with those of their primary care counterparts. The requirements of the PCSP program closely mirror those of the PCMH model and align with other measures and initiatives (FIGURE), such as CMS' EHR Incentive Programs with regard to meaningful use and the Agency for Healthcare Research and Quality's Consumer Assessment of Health Providers and Systems (CAHPS) patient experience tool.

Though PCSPs are still in the early stages of adoption, there are already more than 800 specialty care clinicians, including approximately 100 cardiologists, operating in NCQA-recognized medical homes of this type. Interest in this model is growing, especially among specialties such as cardiology where patients require extensive care across multiple services and as clinicians recognize the value of providing comprehensive, coordinated care for patients through a medical home.

Through the PCSP model, cardiologists can focus on providing coordinated, comprehensive patient-centered care, similar to their "neighbors" in primary care. Additionally, cardiologists benefit from:

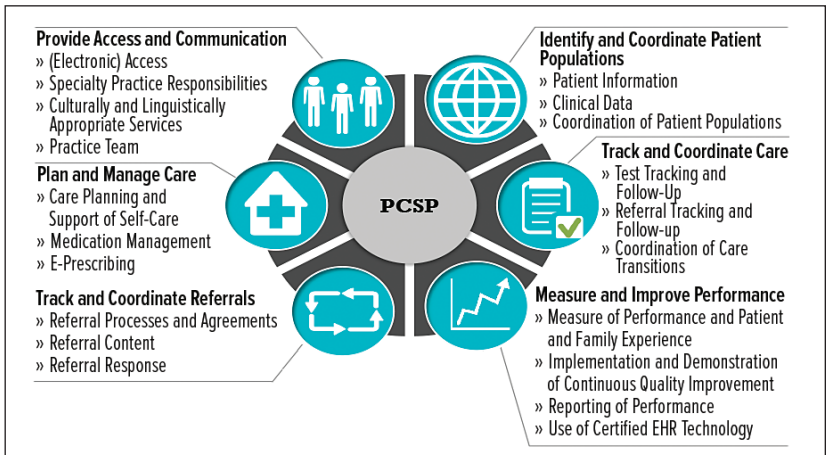
- Opportunities with other providers, payers, and federal/state agencies that might be looking to partner with cardiologists to expand their networks or develop value-based payment arrangements and initiatives.
- Increased volume and/or referrals as more patients are cared for in medical homes and as the medical-home model evolves into the "gold standard" for care.
- Improved access to comprehensive care, as well as enhanced patient safety and satisfaction, and referral management.
- Enhanced processes and efficiencies in care delivery, allowing more time for cardiologists to focus on clinical care and less time spent on other tasks (e.g., phone calls, emails, letters, reports).
- Opportunities to more closely align and coordinate care with primary care.
- New reimbursement mechanisms, which are similar to those currently offered in primary care (e.g., care management fees, bundled payments, global payments) that will support cardiologists under a medical-home model.

What this means is that clinicians in PCMHs and cardiologists in PCSPs will be working from the same "blueprint" in terms of care coordination and management, as well as with similar incentives to make care more accessible and efficient. They'll essentially "reside" in the same medical neighborhood, thereby facilitating navigation for a patient population that requires both primary care and specialty services (and wants the same level of care from all providers).

Establishing a PCSP is not simply a matter of deciding to do so or applying for accreditation. Changing an organization's care-delivery model entails a number of operational and cultural changes, which require considerable time and commitment to implement. However, it is important to note that the PCSP model is emerging as a critical component of specialty care.

Market forces continue to spur the development of primary and specialty care-delivery models that focus on value instead of volume, and specialists who postpone care redesign will struggle to remain viable in the future. Therefore, cardiologists must consider how they can better design care delivery specifically for cardiac patient populations. Cardiologists who truly embrace the PCSP approach will be well positioned to provide better patient care, resulting in improved outcomes and lower costs. With an effective PCSP in place, cardiologists can truly focus on what really matters: delivering value-based care that is truly patient-centered. ■

FIGURE **PCSP Requirements**



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What's really behind your patient's hyponatremia?
Excess vasopressin may be complicating your patient's treatment
Elevated vasopressin levels can cause abnormal water retention, leading to hyponatremia (serum sodium <135 mEq/L).[1,2]
Hyponatremia may increase mortality risk and length of hospital stay and adversely affect outcomes for patients with various medical conditions.[1,3]
Pull back the curtain on hyponatremia
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References: 1. Verbalis JG, Goldsmith SR, Greenberg A, et al. Diagnosis, evaluation, and treatment of hyponatremia: expert panel recommendations. Am J Med. 2013;126(10 suppl 1):S1-S42. 2. Douglas I. Hyponatremia: why it matters, how it presents, how we can manage it. Cleve Clin J Med. 2006;73(suppl 3):S4-S12. 3. Shorr AF, Tabak YP, Johannes RS, Gupta V, Saltzberg MT, Costanzo MR. Burden of sodium abnormalities in patients hospitalized for heart failure. Congest Heart Fail. 2011;17(1):1-7.
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November 2014
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