



# It Takes a Village:

Integrating the Medical Neighborhood

BY EMMA MANDELL AND LILLIAN LEE-CHUN

Providers and payers across the country have a clear mandate: Redesign care delivery models to be patient-centered, comprehensive, and coordinated across all sites of service. To provide a catalyst for care model transformation, providers, payers, states, and the federal government are collectively operating hundreds of primary care-focused, patient-centered medical home (PCMH) programs.<sup>1</sup>

Theoretically, PCMHs require coordination and collaboration between both primary care and specialty care (as well as subspecialty) physicians. Practically, however, the integration of specialty care in PCMH models is often absent (Figure 1). This disconnect is increasingly frustrating for physicians and patients alike, and it challenges the effectiveness of the PCMH model.

*The medical neighborhood model comprises both primary and specialty care Primary Care Medical Home models.*

Primary care physicians (PCPs), who are being held financially accountable for the totality of patient care, are struggling to effectively track referrals and coordinate care with specialists who do not have similar processes or incentives in place.

On the other side, specialists see decreasing volumes, increasing patient acuity, and a market that does

not compensate them for coordinating care.

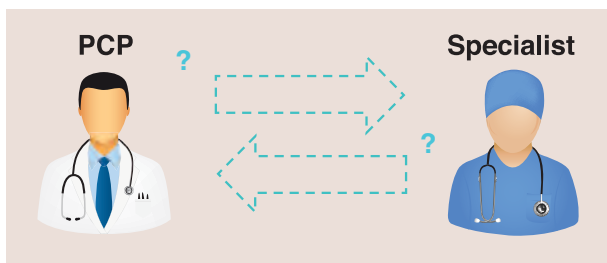
And for patients, it feels like little has changed. If specialists and subspecialists are not working from the same blueprint as primary care, then what kind of results can we realistically expect? This problem will only intensify as the population ages and increasingly develops chronic conditions.

One solution gaining traction is the creation of a *medical neighborhood*—comprising both primary and specialty care PCMH models (see Figure 2). In 2013, the National Committee for Quality Assurance (NCQA) launched the Patient-Centered Specialty Practice (PCSP) recognition program, which is aimed at aligning specialist care models with those of their primary care counterparts. Though still in the early stages of adoption—there are roughly 700 PCSP-recognized specialty care clinicians—interest in this model is growing. Increasingly, providers and payers are adding specialists to their patient-centered care models, thus creating the foundation for medical neighborhoods. Below, we introduce the case and components of the medical neighborhood model and highlight best practices regarding how to make the transition successful.

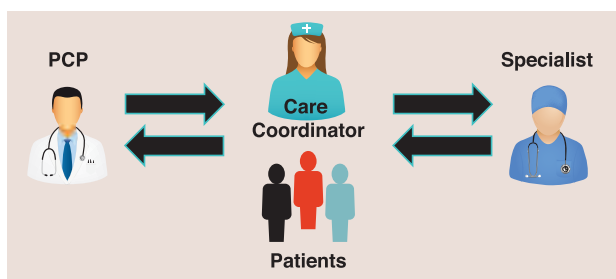
## Closing Gaps

According to NCQA, PCPs report sending patient information to specialists 70% of the time, while specialists report receiving the information only 35% of the time. Conversely, specialists report sending information to PCPs 81% of the time, and PCPs report

**FIGURE 1**  
**PCP/Specialist Current State Disconnect**



**FIGURE 2**  
**Primary/Specialist Middle State Model**



receiving it only 62% of the time. Additionally, from 25% to 50% of referring physicians were unaware of when or where their patients saw a specialist.<sup>2</sup> These statistics underscore the communication and relationship gaps between primary and specialty care physicians today, further emphasizing the need to expand patient-centered principles to specialty care.

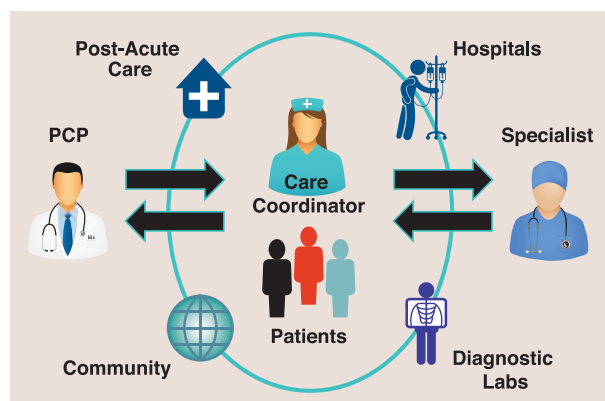
The PCSP model of care provides a blueprint for specialists to help close these gaps and provide seamless, comprehensive care across the full continuum. The incorporation of specialists has the added benefit of building a practice's capacity to better manage increasingly complex patient panels that typically require both primary and specialty care services. For organizations implementing specialist-focused medical home care models, their goals are to clearly identify the role of the specialist in the care pathway, ensure effective communication and collaboration with primary care, align specialist performance through value-based incentives, and set patient-centered standards of care to better serve patient needs and truly manage total population health.

### Growing the Neighborhood

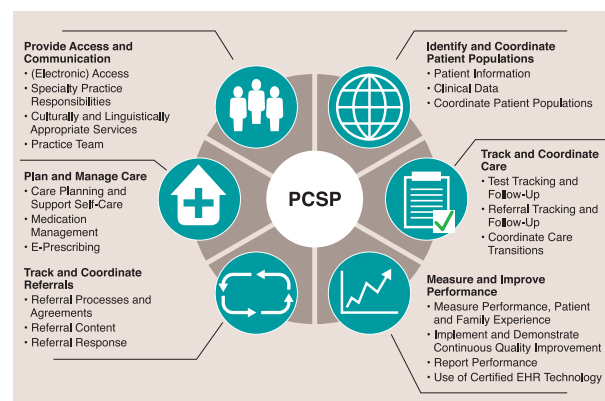
The PCSP program also allows organizations to expand their primary care efforts around medical home models and evolve into all-encompassing patient-centered medical neighborhoods.<sup>3</sup>

The success of primary and specialty care

**FIGURE 3**  
**Medical Neighborhood Future State Model**



**FIGURE 4**  
**Patient-Centered Specialty Practice (PCSP) Care Model**



medical home models and, ultimately, the medical neighborhood model hinges on stakeholder buy-in and commitment, as well as active engagement and bi-directional communication among all parties (see Figures 3 and 4).

### Connecting the Neighborhood

Requirements of the PCSP program closely mirror those of the PCMH model and align with other measures and initiatives, such as the Centers for Medicare & Medicaid Services (CMS) Meaningful Use (MU) program and the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of Health Providers and Systems (CAHPS) tool.

The fact that PCSP standards and elements closely reflect those established for PCMHs is good news for specialists for several reasons:

- **Leveraging of lessons learned.** The growth of PCMHs has led to a number of best practices and lessons learned that specialists can benefit from. From how to engage staff to how often

transition staff should meet, PCMH offers lessons that are transferrable to PCSP.

- **Ease of alignment.** Alignment becomes easier because the two models are built from the same blueprint. The PCSP standards and elements essentially are continuations of the medical home principles into the specialty care setting.
- **Physician buy-in.** The similarities help garner physician buy-in. If PCMH principles have been implemented in neighboring practices with positive outcomes, physician champions will use that success to build the case for implementing PCSP principles at their practice.
- **Auto-credits.** If the primary care practices in a medical group are PCMH-certified, then the practices may qualify for auto-credits that go toward PCSP recognition.

## Early Successes

Over the past two years, the number of clinicians and practices in various medical specialties across the nation operating within NCQA's PCSP program or similar medical home models continues to increase dramatically. The model's success is growing as practices recognize the value of ensuring seamless coordination between primary and specialty care through protocols that facilitate communication and follow-up. Though the PCSP program only began in 2013, today, several organizations successfully operate within the PCSP model and produce promising results. Examples include<sup>4</sup>:

- In Kansas, the University of Kansas Physicians (UKP) Department of Internal Medicine received PCSP recognition for 75 clinicians.
- In New York, Bassett Healthcare's Bassett Cancer Institute received PCSP recognition for 8 clinicians.
- In Massachusetts, the Joslin Diabetes Center received PCSP recognition for 37 clinicians.
- In Oregon and Washington, Compass Oncology received PCSP recognition for 44 clinicians.
- In Texas, Woodlands North Houston Heart Center received PCSP recognition for 10 clinicians.

Of these five organizations, one, UKP, almost immediately recognized the value of expanding its PCMH efforts into its specialty care practices. UKP began its early-adopter PCSP transformation through NCQA immediately following its PCMH transformation in primary care in March 2013. After just one year,

UKP was one of the first organizations to receive PCSP recognition for 75 clinicians across seven specialties, including pulmonology, gastroenterology, endocrinology, rheumatology/allergy, dermatology, infectious diseases, and nephrology.

Eyad Al-hihi, M.D., chief ambulatory officer, vice chair for ambulatory services, and associate professor of medicine for UKP, has been the leader and champion of both the PCMH and PCSP efforts. Dr. Al-hihi agreed that the link between primary and specialty care is broken as the two operate within two different models. This prevents care from being effective or efficient. The solution for Dr. Al-hihi and his team was to ensure that primary care and specialty care are providing consistent care through a structured model that allows for improved and increased efficiencies, job satisfaction, patient satisfaction, quality, and outcomes. For UKP, the best choice was the PCSP model: It provides a blueprint for rolling specialty care into the value-based environment that primary care had been living in for years.

## Lessons Learned

For any organization exploring the PCSP or similar models of care for specialists, Dr. Al-hihi offers a few lessons learned and key considerations as part of the planning process:

- **Engagement.** Spend time engaging administrative and clinical leadership, nurses, front-office staff, and others early on in the process. UKP conducted road shows to introduce PCSP and help each specialty understand program requirements and the value added to their jobs and patients by this new model of care. For those not engaged, conduct a small pilot to show results and further create buy-in.
- **Team designation.** Designate and empower a PCSP project planning team that includes providers, clinical and administrative support staff, IT, and others. UKP teams met weekly for an hour to discuss results of their PCSP efforts and determine next steps for implementation and improvement. Also, by empowering these teams to change their everyday processes, the teams developed creative solutions to follow long after recognition was completed.
- **Project plan and time line.** Develop a clear roadmap with defined time frames for making the transition to the PCSP model of care. UKP delegated tasks to individuals and teams, defined time frames, held each other accountable, and focused on integrating teams to build multidis-



ciplinary relationships. Building a sound plan and solid relationships helps ensure the success of PCSP.

- **PCMH and PCSP.** Developing a PCSP without a PCMH is difficult, as a major focus of PCSP is coordination of care and referral management between specialty and primary care. UKP involved primary care representatives in the development of some components of the PCSP.
- **Staffing and training.** Before hiring new staff, consider the current staffing model and capabilities. Invest resources in developing and conducting training. UKP invests in its people to work smart and developed resources to “work at the top of their license” when possible, rather than hiring new staff. However, UKP did invest in hiring two care coordinators after recognition. Care coordination is a crucial component of the model.
- **Additional revenue.** When done right, the PCSP model creates opportunities for additional revenue for productivity-driven specialists. Through improved workflow, coordination of care, reduced waste, and efficiencies, UKP experienced additional revenue through improved access to care and patient volume. Additionally, UKP is working with payers to negotiate care-coordination fees and shared savings arrangements, inclusive of specialty care providers.

- **Understanding the “spirit” of PCSP.** Knowing the requirements of PCSP is only the first step: understand the spirit of the requirements—live, breathe, and practice in the PCSP model of care.

## Striving for Harmony

As you move toward the future-state goal of population health management, focus on the treatment of populations, not the treatment of one patient at a time. As such, you must ensure primary care and specialty care are working in harmony through a consistent model of care. Today’s reality is that the healthcare delivery system continues to become more convoluted and difficult to navigate for an increasingly complex patient population. Extending PCMH principles and standards to specialty care physicians is revealing itself to be one effective and practical way to better serve patients and allow physicians to focus on clinical issues.

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