Patient-Centered Specialty Practice Recognition
Patient-Centered Specialty Practice Recognition

NCQA’s new evaluation program for specialty practices—Patient-Centered Specialty Practice (PCSP) Recognition—is designed to improve quality while reducing the redundancies and negative patient experiences associated with poorly coordinated care. The PCSP program focuses on proactive coordination and information sharing among specialists and primary care practices, and requires specialty practices to organize care across all the practices a patient visits—and to center care around the patient as opposed to around the care setting. The patient and family or other caregivers are partners in managing conditions treated by the specialist.

The PCSP program asks specialty practices to:

- Develop and maintain referral agreements and care plans with primary care practices.  
  - Communication of timely information helps practices agree on a plan for coordinating and sharing care management for patient referrals. This process is relevant for a variety of specialties.
- Provide superior access to care, including electronically, when patients need it.
- Track patients over time and across clinical encounters to assure the patient’s care needs are met.
- Provide patient-centered care—care that includes the patient (and the patient’s family or caregiver, if appropriate) in planning and goal setting.

The program also evaluates medication management (including medication reconciliation and electronic prescribing); test tracking and follow-up; information flow over care transitions improvement (e.g., from hospital to home); and performance measurement improvement (considering the clinical outcome and the patient experience). The program elements reflect consensus of an expert panel and input from a wide range of stakeholders about the elements most important to achieving better quality and better care outcomes.

The PCSP program has the potential to expand on the increasing success of NCQA’s Patient-Centered Medical Home (PCMH) program. PCSP’s aim is provision of better care through excellent coordination by specialty practices in the outpatient setting, leading to less duplication of procedures and fewer hospitalizations.

Specialty practices that voluntarily submit results through this new program will demonstrate to payers (health plans, states and employers) that they are innovators, committed to improving coordination, outcome and patient experience. For their primary care colleagues, these practices will also demonstrate their eagerness to be the best partners in caring for their shared patients.

Following the same model used by the NCQA PCMH program, specialty practices pursue recognition by completing an online survey and submitting documentation of their operational processes and capabilities that meet NCQA standards. NCQA completes a thorough review to arrive at a recognition determination. Specialty practice recognition status lasts for three years.
**Program Goal: Improving Quality and Coordination**

Many experts agree that information sharing—a prerequisite for care coordination—needs improvement. The new PCSP program focuses on sharing information among a patient’s primary care clinician and all specialists seen by the patient.

Poor communication can result in frustration and wasted time, at best, and in poor quality and safety outcomes, at worst. The examples and research discussed below point to the need for better coordination, with a focus on improving exchange of referral information:

- “Studies have found that 25 [percent] to 50 percent of referring physicians did not know whether their patients had actually seen the specialist to which they were referred… and that physicians both overestimated and underestimated the number of referrals completed” (Mehrotra 2011).
- In an *Archives of Internal Medicine* article, “Referral and Consultation Communication between Primary Care and Specialist Physicians,” the authors found that although primary care physicians report sending a history or reason for a specialist consult nearly 70 percent of the time, specialists report receiving such information only about 35 percent of the time. And while specialists claim to send consult notes and patient advice to primary care physicians nearly 81 percent of the time, primary care physicians report receiving such information 62 percent of the time. Clearly, a structure and guidelines for communication are sorely lacking (O’Malley 2011).
- At a recent conference, Dr. Carol Greenlee, an endocrinologist from Colorado who is piloting a program of better primary care/specialist coordination, said that in the past, “we [got] ‘eyes’ [or] ‘lung’ as the reason for referral. [With the pilot, the physicians] had to write a clinical question and make sure that pertinent data were attached” (Greenlee 2012).

**Recommendations for Use of Patient-Centered Specialty Practice Recognition**

The American College of Physicians white paper, “The Patient-Centered Medical Home Neighbor,” and the Agency for Health Care Policy and Research paper, “Coordinating Care in the Medical Neighborhood,” provided an intellectual foundation for the PCSP program.

Specialists who achieve NCQA PCSP Recognition will show purchasers (consumers, health plans, employers and government agencies) that they have undergone a rigorous and independent review to assess their capabilities and commitment to excellence in sharing and using information to coordinate care. Purchasers can support this program in several ways:

- Ask primary care providers to make referrals to specialists who meet NCQA’s rigorous standards for information sharing and care coordination.
- Choose recognized specialty practices to participate in new initiatives for delivery system reform, including opportunities to benefit from shared savings and better quality (e.g., accountable care organizations [ACO]). Recognition might also be a criterion for specialty practices to earn a “gold card” that allows a clinician to bypass administrative requirements for prior authorization.
- Use the recognition designation as a quality indicator in value-based purchasing initiatives, such as organizing high-performance specialty practices for insurance products with a “preferred tier” of practices for whom patients’ copays are lower. Having good clinical quality measures can be a challenge for specialists: measures are lacking
for many conditions and small patient populations might not support statistically valid reporting.

- Publish recognition status in clinician network directories and consumer/member Web sites.
- Some purchasers may make care coordination payments available to recognized specialists. Many PCMH initiatives across the country began by supporting practices with monthly payments, as the fee-for-service payment system does not explicitly pay for this type of coordinated care. Some purchasers also support a practice’s improvements for going through a PCMH recognition program and for staff devoted to coordinating care—sometimes as a shared resource across several practices. Purchasers may decide to expand on the PCMH model to support PCSPs in some way, whether through different payments or the opportunity for shared savings.

**PCMH Experience: Building Block of the PCSP Recognition Program**

Experience with PCMH has shown:

- Practices think they coordinate care effectively, but often do not. When practices begin to systematically discover what they need to have in place (through the process of responding to clear standards), they can see results.
- Evaluating performance means more than reading standards and checking off a list of requirements. Practices and their patient care teams must learn the standards; develop and agree upon approaches for each important area of practice; and submit documentation for an objective review. These steps are necessary to transform into a practice with an improved workflow and resources devoted to coordination of care.
- Purchasers can combine NCQA standards with quality measure reporting, patient experience surveys and payment initiatives.

That NCQA’s PCMH standards identify practices with “what it takes” to coordinate care has led to important results:

- In 2009 researchers found that Empire Blue Cross and Blue Shield patients who were seen at PCMH practices experienced better preventive health, higher levels of disease management and lower resource utilization and costs, compared with practices that did not pursue PCMH status. PCMH patients had 12 percent and 23 percent lower odds of hospitalization and required 11 percent and 17 percent fewer emergency department services than non-PCMH patients. Risk-adjusted total per member per month (PMPM) costs were 8.6 percent and 14.5 percent lower for PCMH-treated pediatric and adult patients, respectively (DeVries 2012).
Alignment With Federal Requirements for Demonstrating Meaningful Use of Health IT

The PCSP program is aligned with the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record Incentive Program’s Meaningful Use criteria in recognition of the importance of health information technology as a tool for coordinating information and clinical care. Because the program is scheduled for release in March 2013, NCQA will use Stage 1 criteria to evaluate practices until January 1, 2015. Find more information on Meaningful Use at http://www.healthit.gov/.

Multiple Levels of Performance

The NCQA PCSP program offers three levels of specialty practice recognition. Level 1 is awarded to a practice that meets the minimum score of 25 points (of 100) and all mandatory ("must-pass") standards. Practices with higher scores can qualify for higher levels of recognition. As with the PCMH program, multiple levels of recognition let practices evolve over time.

Considered foundational to the PCSP model, practices must receive at least a 50% score on the following must-pass elements:

- The practice has agreements with other practices to manage referrals effectively, as emphasized in the thinking and experience of the developers of the PCMH Neighborhood and related initiatives.
  - NCQA’s standards call for agreements to address methods of communication with specialty practices, patients and families; confirmation of receipt and acceptance of referrals with date and time of appointment; specific patient information needed from referring specialty practices; requested timing of the referral response to specialty practices, patients and families about results and treatment.
- The practice states expectations and monitors its performance against those expectations to ensure a timely and complete response to primary care practitioners.
- The practice uses team-based care.
  - This includes defining roles for clinical and nonclinical team members; holding regular team meetings or having a structured communication process focused on patients; using standing orders for services; training expectations; and involving members of the team in quality improvement activities.
- The practice manages medications.
  - This includes reviewing and reconciling medications for which patients received prescriptions from specialty practices in other care settings or visits, and sharing information about new prescriptions from the specialty practice with patients/families/caregivers.
- The practice has a quality improvement program.
  - This includes setting goals and acting to improve on at least three clinical quality or utilization measures and at least one patient experience measure; improving timeliness of patient access; tracking results over time; and achieving improved performance on some measures.

Developing NCQA’s Specialty Practice Recognition Program
NCQA developed this program through a multi-stakeholder process, drawing on a wide range of expertise.

NCQA convened a panel of experts to develop the program elements and standards.

Neil Kirschner, PhD (Co-Chair)
Senior Associate, Regulatory and Insurer Affairs
American College of Physicians

Lee Partridge (Co-Chair)
Senior Health Policy Advisor
National Partnership for Women and Families

Bruce Bagley, MD
Medical Director for Quality Improvement
American Academy for Family Physicians

Maureen Corry, MPH
Executive Director
Childbirth Connection

John Cox, DO, MBA
Texas Oncology—Methodist Dallas Cancer Center

Allen Dobson, MD
CEO
Community Care of North Carolina

Carol Greenlee, MD
Practitioner
Western Slope Endocrinology

Pamela Hymel, MD, MPH
Chief Medical Officer
Walt Disney Parks & Resorts

Craig Jones, MD
Director
Vermont Blueprint for Health

Talmadge King Jr., MD
Chair, Department of Medicine
University of California

Carrie Klett, MD
Westside OB-GYN Center, Pennsylvania

Ronda Kotelchuk
CEO
Primary Care Development Corporation

J. Kersten Kraft, MD
President
Santa Clara County Individual Practice Association

Kevin Malone
Public Health Analyst
SAMHSA

David May, MD, PhD
Cardiovascular Specialists, PA

Rhonda Medows, MD
Chief Medical Officer
UnitedHealthcare

Marci Nielsen, PhD, MPH
Executive Director
Patient Centered Primary Care Collaborative

Richard Popiel, MD
Senior Vice President, Health Care Services and Chief Medical Officer
Regence Health Plan

Craig Pollack, MD, MHS
Assistant Professor, Department of Medicine
Johns Hopkins Medical University

Jacob Reider, MD
Chief Medical Officer
Office of the National Coordinator for Health Information Technology, HHS

Fan Tait, MD
Associate Executive Director
American Academy of Pediatrics
The panel defined the key program elements and scoring weights and determined which program elements should be “must-pass” and which are critical factors in the evaluation.

A draft of the program elements was made available for Public Comment. We received comments from a variety of perspectives, in particular from physician specialty groups. NCQA pilot-tested the standards with specialty practices, which gave us insight into practice capabilities and showed us how effectively our standards captured practices’ interactions and functions. NCQA presented the program to various stakeholder committees (i.e., the Consumer Advisory Council, the Public Sector Advisory Council and the Purchaser Advisory Council).

Responding to Public Comment feedback, the panel revised the standards and sent the final program to NCQA’s Clinical Programs Committee (a multi-stakeholder committee) for review and approval. NCQA’s Board of Directors had final approval.

References


Greenlee, C. 2012. Presentation to NCQA’s 7th Annual Public Policy Conference.

