Adapting the Patient-centered Specialty Practice Model for Populations With Cirrhosis

Sarah K. Meier,* Nilay D. Shah,* and Jayant A. Talwalkar*,‡,§

*Division of Health Care Policy and Research, Department of Health Sciences Research; ‡Division of Gastroenterology and Hepatology; and §William J. Von Liebig Center for Transplantation and Regenerative Medicine, Mayo Clinic, Rochester, Minnesota

United States health care is moving rapidly from volume- to value-based reimbursement. An essential part of this movement will be the development of alternative payment models where a specific bundle of care (colonoscopy), episode of care (a year of care for attributed Crohn's patients), or ongoing care of a specialty-centric patient population (patients with cirrhosis) are covered within a contract that links health outcomes, quality of care, and payment together. Gastroenterologists are slowly becoming aware of these concepts. Primary care has its patient-centered medical home and now specialists have a patient-centric specialty practice where patient populations are cared for principally by a specialty practice within a well-defined care delivery structure. Previous Road Ahead columns have illustrated these concepts, and this month, Meier and colleagues provide an excellent definition and example of how practices can participate in this new world order.

John I Allen, MD, MBA, AGAF
Special Section Editor

The Patient Protection and Affordable Care Act secures access to health insurance coverage for many previously uninsured individuals, while transforming the structure of health care delivery to promote high value care that is coordinated and patient-centered.[1] The development of innovative care delivery models is a key feature of this transformation. In turn, patient-centered medical homes (PCMHs) have proliferated in number, with PCMH-related pilot and demonstration projects spanning numerous federal agencies.[2]

Defining the Patient-centered Medical Home

The concept of the PCMH predates the Patient Protection and Affordable Care Act, with its origins in the American Academy of Pediatrics' 1967 discussion of the medical home. In 2007, a joint release by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association defined the PCMH as "an approach to providing comprehensive primary care for children, youth and adults." Furthermore, the PCMH would serve as "a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." Several key principles underscore the PCMH model; the patient has a personal physician, and care is physician-directed at the level of the practice, oriented around the whole person, and coordinated to ensure the highest quality and safety of medical care. The PCMH facilitates enhanced access to care, and the payment structure incentivizes and compensates high-quality care delivery.[3]

Advent of the Patient-centered Specialty Practice

In 2013 the National Committee for Quality Assurance (NCQA), which operates the Patient Centered Medical Home Recognition program, released a set of standards governing the recognition of the patient-centered specialty practice (PCSP).[4] Similar to the PCMH model, the PCSP model places the patient at the

Resources for Practical Application
To view additional online resources about this topic and to access our Coding Corner, visit www.cghjournal.org/content/practice_management.

Abbreviations used in this paper: **NCQA, National Committee for Quality Assurance; PCMH, patient-centered medical home; PCSP, patient-centered specialty practice.**

Most current article

1542-3565/$36.00
http://dx.doi.org/10.1016/j.cgh.2015.12.034

center of care delivery. Key functions of the PCSP include placing the patient at the center of care, sharing of information, and coordinating across all practices (specialty and primary) for patients.[5] The NQCA outlines 6 standards for PCSP recognition; these standards focus on planning, management, tracking and coordination of care, performance measurement, performance improvement, referrals, communication to patients, care access, and coordination and management for populations.[5]

Centering Patient Care in the Specialty Practice

With the release of the NCQA PCSP standards, provider groups and regulators should work to identify circumstances under which the PCSP might best operate as an effective model for the populations they serve. For example, in the case of mental illness that is both severe and persistent, the creation of a PCMH may disrupt existing patient-provider relationships, increase fragmentation of medical care, and position poorly equipped providers at the center of a care process that requires greater specialization.[6]

Drawing from this example, we suggest that select patient populations with advanced chronic liver disease may benefit from the development of patient-centered care models that operate such as a PCSP. This may include patients with compensated cirrhosis and other comorbid illnesses such as diabetes mellitus or depression, populations with active complications of portal hypertension, or patients who await or have received liver transplantation.[7,8] We suggest examining the potential value of this model in circumstances where the complexity of patient needs or the sensitivity and vulnerability of the patient circumstance may best be managed by an established, trusted, and specialized provider. In the case of patients with cirrhosis and substance abuse from alcohol, a hybrid specialty model that incorporates addiction medicine, social work, and psychiatry providers in addition to hepatologists and allied health providers may be warranted.[7]

Designing the Patient-centered Specialty Practice for Populations With Cirrhosis and Liver Transplant Recipients

Practices and providers should carefully assess the context for PCSP adoption, identifying whether the specialty care model will promote greater efficiency and quality than that realized in the absence of a PCSP model. The PCSP model should align with patient needs, considering factors such as cause of disease, disease stage, comorbidities and complications, and socioeconomic factors. Although the NCQA PCSP standards should guide model development, there are specific needs and complexities of cirrhosis and liver transplant populations that may prove highly relevant in identifying 1 or more ideal model designs. This may entail development of additional PCSP standards beyond what is recognized by NCQA.

Table 1 outlines key questions providers might address when considering the development of the PCSP in this patient population. We divide these questions into 3 main categories: (1) understanding the context for PCSP model adoption, (2) identifying opportunities to align the PCSP model with the specific needs of the patient population, and (3) selecting a model design. Incorporating careful consideration of the questions highlighted within each of these categories can help inform practitioners on the merits of various PCSP models.

Understanding the Context for Patient-centered Specialty Practice Adoption

Drawing from Alakeson et al,[9] we suggest that providers embarking on PCSP model adoption first consider how the quality of care and strength of patient-provider relationships for the target population will improve. The selection of an appropriate patient population is a key determinant in the answer to this question. Focusing specifically on the cirrhosis population, the PCSP may need to be directed toward a disease stage (ie, decompensated cirrhosis) where the specialist is the most frequent and continuous point of system access. Similarly, the PCSP might yield the greatest gains in quality when access is a function of requiring specialized knowledge in the day-to-day management of care delivery (ie, compensated liver disease or long-term post–liver transplant recipients).

The case for the PCSP may be particularly strong in instances where the primary care provider lacks sufficient knowledge to appropriately manage patient care. For example, treatment of mental and behavioral health conditions that are comorbid with cirrhosis may best be suited to a specialized and established care team that has secured patient trust. Many transplant centers in the United States have explicitly created teams in this regard