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Patient Centered Specialty Practice: A Value Based Care Solution for Urology Groups

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Abstract

Introduction: Patient centered medical homes have been traditionally viewed as the most logical model for the treatment and coordination of care for individuals with various conditions, although there are certain diseases for which urology groups in the form of patient centered specialty practices are better suited. We assessed the current state of urology involvement in the patient centered medical home to suggest implementation strategies for which urology based, patient centered specialty practices should be the primary contact for advanced disease states.

Methods: We conducted a review of published studies using PubMed®/MEDLINE® from database inception to 2017. Studies that contained data on urology involvement in patient centered medical homes were included, as well as governmental and agency produced reports.

Results: There is a consensus in the literature regarding an escalation of cancer care costs that are not linked to improved patient satisfaction or outcomes. Emphasis is now being placed on innovative treatment models in oncology that are based on the patient centered model and alternative, value based payments as opposed to the traditional fee-for-service approach. The oncology medical home, in the form of a patient centered specialty practice, may mitigate some of the financial burden while providing a higher quality of care and improved patient satisfaction.

Conclusions: By incorporating high quality cancer care standards such as those established by the Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine, and the Centers for Medicare and Medicaid Services urology practices can position themselves as patient centered specialty practice facilities recognized by the National Committee for Quality Assurance, which are capable of becoming the primary medical homes for patients with chronic urological conditions.

Key Words: urology, patient-centered care, prostatic neoplasms, Medicare Access and CHIP Reauthorization Act of 2015

Abbreviations and Acronyms

APC = advanced prostate cancer
 APM = alternative payment model
 CCM = chronic care management
 CMS = Centers for Medicare and Medicaid Services
 CPIA = clinical practice improvement activities
 EOL = end of life
 GU = genitourinary
 IT = information technology
 MACRA = Medicare Access and CHIP Reauthorization Act
 MIPS = merit based incentive payment system
 NCQA = National Committee for Quality Assurance
 PCMH = patient centered medical home
 PCSP = patient centered specialty practice
 U.S. = United States

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Declaration were followed in lieu of formal ethics committee approval; institutional animal care and use committee approval; all human subjects provided written informed consent with guarantees of confidentiality; IRB approved protocol number; animal approved project number.

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As the United States health care delivery system undergoes a paradigm shift to a value based payment system,¹ urologists along with other physicians are given the task of transforming their internal practices. More specifically, moving forward with this process entails utilization of care coordination and standardization to yield greater value in health care by improving the quality of patient care while decreasing costs.²

During the last decade urology practices have undergone their own transformation, with the development of larger urology groups with resources that integrate health care delivery. In particular many urology groups now have a continuum of care for various disease states such as prostate cancer, where the provision of care that is initiated from within the urology group incorporates diagnosis, anatomical pathology, radiotherapy, surgery, patient education and the services of APC centers to provide a true multidisciplinary approach to prostate cancer treatment.² As such, integrated urology groups have evolved from single specialty groups to integrated care delivery systems geared toward treatment of urological disease states. Furthermore, urology groups, through development of APC centers, have established the basic tenets of successful value based payment systems, ie care coordination and navigation.

With the development of integrated urology practices the foundation has been laid for value based care. Integrated urology groups are also poised to leverage the existing health care structure to provide even greater value by creating patient centered specialty practices. The National Committee for Quality Assurance has also extended the concept of medical homes to specialty practices through what is now referred to as NCQA PCSP recognition.³ More specifically, specialty practices such as urology groups that strive to provide easy access, open communication and care coordination services can earn recognition as an integral component of the health care community that supports the medical home. Accordingly a PCSP offers several options in terms of reinventing urology group practice models, operations and value based care. Indeed, the principles of a strategically built specialty practice model emphasize reorganization of the traditional urology group practice to one that highlights fundamental attributes that include 1) a comprehensive approach to GU cancer care, 2) a personal relationship with a specialist led team, 3) a coordinated and enhanced support system, and 4) a reimbursement approach that corresponds with the cancer care team strategy.⁴

A successful PCSP model is dependent on effective care coordination as well as development of long-term physician-patient relationships that are built through value based care metrics and synchronization of care team methodologies. With implementation of a PCSP urology groups can evolve

toward better quality care and higher rates of patient satisfaction than previously achieved through the traditional fee-for-service structures. Although a PCSP must maintain several core competencies, certain aspects can be analyzed to identify the best operational solution.

In 2012 the former Institute of Medicine (current Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine) developed a framework for delivering high quality cancer care that includes 6 interrelated components. These items consist of 1) patient centered communication that supports patients making informed decisions through medical consultation that facilitates shared decision-making, 2) interprofessional cancer care teams that focus on patient preferences, values and needs but also coordinate with caregivers or other support groups, 3) evidence-based cancer care, which encompasses approaches with demonstrated efficacy through clinical trials and comparative effectiveness studies, 4) an evolving IT cancer care system that promotes enhanced delivery and quality of care, performance improvement and data on patient outcomes, 5) incorporation of novel evidence into clinical practice to improve practice guidelines, diagnosis and prognosis assessments, innovative strategies and delivery of cancer care, and 6) affordable, accessible cancer care that is available to all patients and is aligned with value based reimbursement that promotes high quality, patient centered care and eliminates unnecessary interventions.⁵ Research suggests that the PCSP can achieve increases in quality of care and reductions in overall costs associated with traditional treatment approaches by incorporating the aforementioned components into the infrastructure of the specialty practice.²

Although PCMHs have traditionally been thought of as being the most logical medical home for the management and coordination of care for individuals with various conditions, including chronic conditions, there are certain diseases for which urology groups in the form of PCSPs are better suited. That is compared to their primary care counterparts, urologists are able to carry out particular medical functions for diseases such as prostate and bladder cancers more specifically. For example a patient with metastatic castrate resistant prostate cancer often begins advanced cancer therapeutics including sipuleucel-T and oral oncolytic through the urology practice, which in this instance is filling the role of PCSP. During this treatment period the urologist is the primary contact for all health issues. Subsequently once the cancer treatment is complete, the PCMH resumes the primary contact with the patient, and followup visits with the PCSP are coordinated by the PCMH.⁶ The PCMH neighborhood may then also serve as the focal point to coordinate care between urology and medical oncology

groups. We assessed the current state of urology based PCSP involvement in PCMH care to suggest strategies by which more urologists may leverage existent structures and novel resources (eg advanced prostate cancer centers utilizing care coordination and nurse navigation) to facilitate the transition toward PCSP as the primary medical practice for advanced urological disease states.

Methods

We reviewed PubMed/MEDLINE for studies published from database inception to 2017. Series containing data on urology involvement in PCMH were included. The search terms that were used included but were not limited to “urology,” “urologist, oncology,” “prostate,” “prostate cancer,” “genitourinary cancer” and “genitourinary neoplasms,” as well as “cancer treatment” in combination with the terms “medical home,” “PCMH,” “PCSP” and “care model.” Initially a general search was conducted, and the advanced search options were used as well. Advanced search options included the use of Boolean expressions such as “AND” and “OR” in addition to limiting the results to peer-reviewed journals and articles from the last 5 years. Dissertations, commentary articles and animal model studies were excluded from the database searches. Articles that discussed urology services in practices outside of the U.S. were also excluded.

The search results were categorized into nonurology and urology related articles, with those pertaining to urology

being the focus of this review. Titles and abstracts were screened and relevant studies were chosen. Relevant articles were selected according to title, and an independent reviewer screened studies and read full texts of relevant articles. The reviewer assessed full texts for inclusion criteria and extracted data (see figure). [F1]

A nonsystematic review was also conducted to identify governmental and agency produced reports as well as studies that focused on nonurological survivor concerns. In addition, on-site research was conducted in 10 integrated urology practices across the U.S. to understand and document the existent care coordination and navigation infrastructure. Specific issues identified from the on-site research involved provider dynamics, IT/software, clinical pathways, care coordination infrastructure and navigation programs. A total of 9 articles and 2 reports were ultimately identified that met the search criteria and were analyzed for this review. Urology relevant articles were categorized into review articles, clinical studies and reports, all of which were used to generate a narrative synthesis of information. Best practices were also identified from the on-site current care coordination and navigation research at the 10 sites.

Results

The results of the search indicated a substantial level of agreement within the oncology literature regarding the observation that there is dramatic escalation in cancer care costs that has not directly translated into improved patient

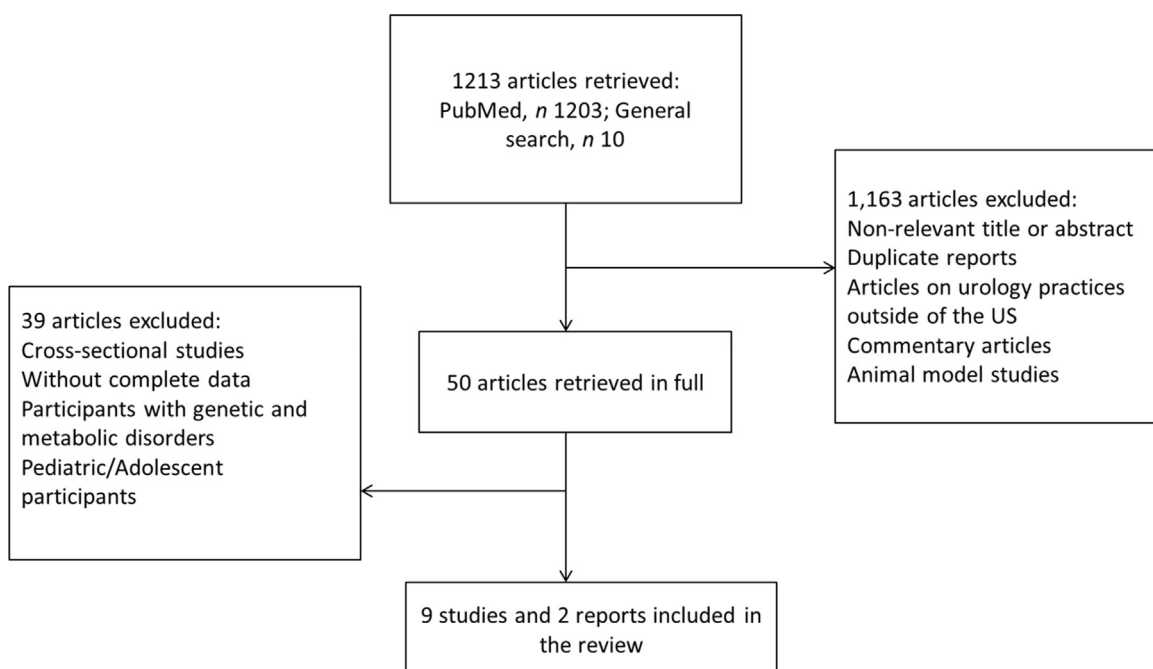


Figure. Flowchart of systematic review

satisfaction or outcomes.^{7–12} There is also consensus that the oncology medical home has already proved to be an optimal means of mitigating the current financial risks as well as proactively preventing unnecessary emergency room visits, hospitalizations and complications.^{9,13,14} Furthermore, research suggests that high quality cancer care standards, which are currently being refined, provide a useful framework for oncology centers (eg urology practices) that wish to incorporate medical homes principles into the infrastructure. Implementing such frameworks better equips such practices to assimilate into the new reform configurations and also prepare for NCQA PCSP recognition.^{7,8} An additional study clarified that finding a solution to bringing value and fair costs into this equation is the patient centered model in oncology as this setting facilitates partnerships between specialty physicians and individual patients as well as their families, when appropriate, in settings that are more convenient for the patient.^{9,13}

Despite the agreement in the oncology literature, no articles were identified that indicated any urology practice had received NCQA PCSP recognition, and a 2012 study indicated that the first NCQA recognition of an oncology practice as a level III PCMH was not granted until 2010.¹⁴ In checking the most recent NCQA records 2 urology practices have been certified as PCSP.

According to a study by Sakshaug et al, a full three fourths of urology practices meet the required qualifications for a medical home.¹⁵ The authors explain that the PCMH has been widely viewed as the first resource for primary care, while less focus has been placed on specialty practices such as urology centers. They indicated that for certain chronic urological diseases such as prostate cancer and other GU cancers ongoing patient care may be better facilitated through a urology practice. Additional findings from the study show that in terms of obtaining medical home recognition urology practices completed larger percentages of “must pass” elements and received higher scores on average than primary care facilities in areas such as medical home readiness. Urology centers also demonstrated better performance ratings than primary care centers for use of electronic patient tracking systems and test results. The researchers also evaluated the practicability of transferring primary care patients with GU cancers (eg prostate, testicular, bladder and kidney cancers) to urology centers. It was observed that reallocating half of the patients would lead to less than 4 additional days of work yearly for the urologists. Therefore, the findings indicate that specialty practices such as urology centers are capable of taking on the primary role of patient care for chronic conditions and support the need for this innovative reform of health care delivery.

Colligan et al reported that several oncology medical homes have been established across the U.S. based on the principles of enhanced access to cancer care, evidence-based diagnoses and treatments, and triage pathways.¹⁶ This concept encourages individuals to manage their condition in outpatient settings when possible, thereby preventing unnecessary hospitalizations. Furthermore, the patient navigation programs partner individuals with nonclinical navigators who support patient values and personal needs, communicate patient concerns to physicians, guide patients to preferred care resources and facilitate EOL goal setting. Both of these models have led to significantly reduced patient costs and decreased hospitalizations during the EOL period in comparison to matched subjects. These findings indicate that urology based PCSPs that incorporate features of the aforementioned interventions can improve their ability to provide a more comprehensive approach to GU cancer care as well as EOL outcomes.

Colligan et al also described the utilization outcomes and cost assessment for 3 cancer care models for Medicare recipients, ie patient navigator programs, oncology medical homes and palliative care centers.¹⁶ By comparing participants who died during the study to matched subjects the patient navigation programs and oncology medical homes exhibited reduced patient costs in the last 90 days of life as well as fewer hospitalizations during the last 30 days of life. The patient navigation programs were also linked to fewer emergency room visits during the last 30 days of life and increased hospice admissions during the last 2 weeks of life. The results of this study also support the best practices that were identified from the on-site current care coordination and navigation review.

Before the advancement of oncology centers as medical homes, patients often reported diminished quality of life, depression and anxiety, especially terminally ill patients with cancer, who often expressed a desire to receive palliative care and emotional/spiritual support as opposed to inpatient hospitalization and aggressive treatments.^{11,14,16} Urology based PCSPs offer an alternative to patients with GU cancers.

Finally, a study by Huang and Rosenthal revealed that PCMH initiatives have previously struggled to build effective partnerships with specialty practices that lacked the capabilities to provide patient care collaboration.⁸ In addition, from within the patient centered medical neighborhood specialty practices are often given limited access to patients whose care is restricted by their primary care providers, especially for specialists who do not adopt a more value based approach to patient care. According to Huang and Rosenthal, the success of the medical neighborhood is dependent on proper alignment between the PCMH and its counterparts in terms of their long-term health care goals for

shared patient populations.⁸ They conclude by describing the PCSP as the optimal complement and specialty analogue to the PCMH model.

PCSP and MACRA

The Centers for Medicare and Medicaid Services in 2016 released rule changes that shifted the existing reimbursement formula to a new value based reimbursement system as mandated by MACRA, consisting of 2 quality payment programs, ie MIPS and advanced APM. CMS chose 2017 as the transitional year for adoption of these payment models.

MIPS was developed based on existing elements of the Physician Quality Reporting System and Meaningful Use standards with the addition of a new scoring initiative known as CPIA as well as measure of cost (resource use). MIPS was organized to be facilitated as follows.¹⁷ Four components would be scored and the results combined to produce a total composite performance score. All MIPS physicians would be graded on a curve, with providers receiving a -4% to +4% adjustment to their Medicare reimbursement during year 1, and -9% to +9% by year 4 based on their scores. There would be a potential 3 times multiplier for exceptional performances (+27%).

The following terms apply to advanced APM, which is the alternative track.¹⁷ Eligible professionals would have 20% of eligible Medicare patients or 25% of their Medicare Part B payments through a qualified APM. Those providers eligible for advanced APM would be excluded from the requirements of MIPS. Advanced APM physicians would receive a 5% lump sum bonus yearly.

Each practice could participate in MIPS, advanced APM or both. There would be a decrease in Medicare reimbursement for practices not participating unless they met certain criteria (eg low overall Medicare collections).¹⁷

Practices that are PCMHs or PCSPs have a distinct advantage in MACRA.¹⁸ PCSPs that earn recognition automatically receive full credit in the MIPS/CPIA category, with automatic CPIA credit making up 15% of the MIPS score that indicates whether a practice should receive penalties or bonuses. Indeed, a PCMH that is expanded under the CMS Innovation Center authority may qualify as an APM, thereby allowing the qualifying practice to participate in the merit based incentive payment system as well, if not qualifying outright for advanced APM.

NCQA Recognition

Institutions such as CMS have traditionally put their faith in the PCMH delivery model because it works. Practices can

transform into well accepted PCSPs through a recognition program that can make specialty care into what patients want and need it to be. Urology practices can receive PCSP recognition from the NCQA, for which the standards are aligned with the CMS Meaningful Use standards. PCMH and PCSP are the leading recognitions programs, and in addition to being eligible for an automatic credit, such practices are better equipped to perform well in other scored merit based incentive payment categories such as clinical cancer care quality, resource use and health IT (eg electronic health records). The NCQA has established standards for the PCSP recognition program, which consist of 1) tracking and coordinating referrals, 2) providing access and communication, 3) identifying and coordinating patient populations, 4) planning and managing care, 5) tracking and coordinating care, and 6) measuring and improving performance (Appendix 1).¹⁹

Urology practices should accordingly strive consistently to develop an effective PCSP, which involves incorporating key strategies such as delegating a head physician and project manager, dedicating time to implementing PCSP principles, enhancing care team organization and developing a meaningful use report. Additional key aspects to developing a PCSP include 1) forming a truly integrated team and providing continuing education/training for the care team to ensure that each patient receives a comprehensive care plan, 2) participating, directly or indirectly, in CMS based payment initiatives, 3) clearly defining staff roles and the requirements for data sharing, 4) developing specific goals (eg evidence-based care, value based payment, best practices), 5) improving referral tracking, which includes the timely processing of referral submission, acceptance, consultation with specialists and consultation completion, 6) standardizing the referral response by developing a template for consultation communication and followup that incorporates quality metric requirements, value based payment documentation and proper coding, 7) expanding patient access by standardizing the workflow, marketing directly to medical home neighbors and soliciting bids by other medical homes for business, 8) improving test tracking and cancer care coordination by standardizing clinical documentation through electronic health records and other forms of health IT, 9) increasing patient satisfaction by periodically conducting Clinician and Group Consumer Assessment of Healthcare Providers and Systems surveys, providing a feedback box and/or online rating, 10) being practical and eliminating waste regardless of its source, 11) being fair and practical in gain sharing when the practice experiences positive gains, and 12) ensuring patient needs are always the main focus of newly implemented initiatives.^{8,19,20} According to Robinson, developing an

effective specialty practice requires making a greater investment in the infrastructure and office staff, and implementation of the aforementioned strategies results in cost savings, reduction in unscheduled visits and increased patient satisfaction.²

Chronic Care Management for Better Care Coordination

Urology practices can also benefit from incorporating the chronic care management model into their infrastructure. CCM consists of a set of CPT codes rolled out by CMS in 2015 in an effort to encourage, reimburse and fund care coordination activities. CCM is an additional route by which specialty practices such as urology centers can receive reimbursements for coordinated care efforts. This particular route involves nonface time services that are provided to Medicare recipients who have 2 or more chronic conditions. CMS requires that such services be billed under the CPT code 99490. Appendix 2 lists additional key elements that are required to be able to bill under the CPT codes.²⁰

The systemized approach to utilization of CCM and billing under the CPT codes 99487, 99489 and 99490 can provide a revenue stream that supports a more robust navigation/care coordination effort that is in accordance with a PCSP model. Accordingly recent literature suggests that chronic care models have contributed to the development of the specialty practice concept. In particular CCM principles have been demonstrated to provide higher quality health care for patients with chronic conditions at lower costs.²¹

Discussion

The patient centered model of the PCSP entails treating patients through a more comprehensive approach that incorporates emotional, social and physical health as well as individual values, preferences and needs into diagnosis and treatment. Accordingly the practicing physician at the PCSP must be able to oversee each of these care aspects using a coordinated and highly organized approach. A well equipped PCSP should also be able to use health IT to effortlessly integrate patient care to ensure that accurate information can be continuously shared between cancer care team members.²²

Many urology groups have evolved into integrated practice units and developed advanced care coordination structures within APC centers. Those practices that are not as far advanced have an opportunity to access CMS CCM funding for development of care coordination infrastructure. Through development of care coordination urology groups

may also be well positioned to receive PCSP recognition. Thus, many groups can achieve success in the value based payment paradigm as put forth by CMS. Although there are costs to implementing a PCSP, and specialty groups should take care to treat specialty specific disease states within the confines of CCM, the benefits of greater quality and increased revenue are likely well worth the investments.

Current research indicates that the success of the medical neighborhood depends on effective alignment between the PCMH and its counterparts regarding long-term cancer care goals for shared patient populations, with the PCSP being implicated as the optimal complement to the PCMH model.⁸ Urology practices that successfully implement value based initiatives as well as comprehensive health care services that focus on the whole person orientation have the potential to become forerunners in regard to long-term treatment for chronic urological conditions. To date, research indicates that the percentage of urology practices involved in PCSP and PCMH is low,¹⁵ although as more urology practices consider the benefits of seeking PCSP recognition, there may be a dramatic shift toward specialty care management for advanced disease states.

Conclusions

Overall, current urology based PCSPs and those seeking NCQA recognition should be founded on the main principles of 1) patient centered care, 2) strong patient-physician relationships and 3) the whole person orientation. These principles afford patients improved access to high quality, coordinated care through a specialty practice that is equipped to treat chronic conditions (eg GU neoplasms) through advanced services, medical technologies and disease state focus that are not typically available to primary care medical homes. Additional responsibilities of a qualified PCSP include being well equipped to offer services such as preventive interventions, acute and chronic care management and wellness promotion.²³ However, the PCSP should also function as an integral part of the PCMH neighborhood to ensure that all aspects of individual health are being appropriately managed. By incorporating and adhering to the established high quality cancer care standards urology practices can position themselves as NCQA recognized facilities that are capable of becoming primary medical homes for patients with chronic urological conditions. More importantly, the integrated urology practice is readily equipped to be a PCSP for persons afflicted with advanced disease states. Therefore, urology groups need to take the initiative for management in specific populations that are suitable for specialized care.

Appendix 1.

PCSP Recognition Standards and Elements

Recognition Levels	Required Point	Must-Pass Elements
Level 1	25–49 points	6 of 6 elements are required for each level
Level 2	50–74 points	Must-pass elements score must be $\geq 50\%$
Level 3	75–100 points	Must-pass elements are in BOLD CAPITAL LETTERS

100 Points, 26 Elements, 6 Must-pass elements

Points	Standard/Element
22	PCPS 1: Working with Primary Care and Referring Clinicians
4	Element A: Establishing Relationships with Primary Care and Other Referring Clinicians
4	ELEMENT B: MANAGING INITIAL REFERRALS
3	Element C: Assessing Initial Referral Content
4	ELEMENT D: Assessing Initial Referral RESPONSE
4	Element E: Transition to Primary Care
3	Element F: Connecting Patients With Primary Care
18	PCSP 2: Provide Access and Communication
5	Element A: Access
3	Element B: Electronic Access
3	Element C: Specialty Practice Responsibilities
3	Element D: Culturally & Linguistically Appropriate Services (CLAS)
4	ELEMENT E: THE PRACTICE TEAM
10	PCSP 3: Identify and Coordinate Patient Populations
2	Element A: Patient Information
2	Element B: Clinical Data
3	Element C: Implement Evidence-Based Reminders for Specialty Care
3	Element D: Implement Evidence-Based Decision Support
18	PCSP 4: Plan and Manage Care
8	Element A: Care Planning and Support Self-Care
6	ELEMENT B: MEDICATION MANAGEMENT
4	Element C: Use Electronic Prescribing
16	PCSP 5: Track and Coordinate Care
5	ELEMENT A: TEST TRACKING AND FOLLOW-UP
6	Element B: Referral Tracking and Follow-Up
5	Element C: Coordinate Care Transitions
16	PCSP 6: Measure and Improve Performance
4	Element A: Measure Performance
4	Element B: Measure Patient/Family Experience
4	ELEMENT C: IMPLEMENT & DEMONSTRATE CONTINUES QUALITY IMPROVEMENT
2	Element D: Report Performance
2	Element E: Use Certified EHR Technology

Adapted from NCQA.¹⁹**Appendix 2.**

Chronic Care Management Services and CPT Codes

CCM	
CPT 99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: <ul style="list-style-type: none"> • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month	
Complex CCM	
CPT 99487	Complex chronic care management services, with the following required elements: <ul style="list-style-type: none"> • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
CPT 99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.	

Adapted from CMS.²⁰

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