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DOI: 10.1056/NEJMp1400254

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Transforming Specialty Practice — The Patient-Centered Medical Neighborhood

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The patient-centered medical home (PCMH) is a well accepted primary care delivery vehicle in the United States.¹ The National Committee for Quality Assurance (NCQA) has recognized nearly 27,000 clinicians at more than 5000 sites throughout the country in its PCMH program. State and private payers have their own certification criteria. As PCMH efforts have spread and met with mixed success, some observers have noted that refurbishing primary care is probably necessary but not sufficient for addressing the fragmentation of care and underlying cost growth. Primary care services themselves account for only 6% of total health care spending. Moreover, attempts to make primary care solely accountable for global costs raise the specter of gatekeeping.²

The term “medical neighborhood” has been coined to capture an expanded notion of patient-centered care, in which the PCMH is located (virtually or otherwise) centrally and is surrounded by specialty clinics, ancillary service providers, and hospitals.¹ The concept of the medical neighborhood, however, has been

based almost entirely on the notion of primary care practices as integrators of downstream specialty care. Despite widespread reform of primary care practice, specialty practices have remained largely unchanged.

Many PCMH initiatives have wrestled with building effective partnerships with specialty practices that lack the capabilities and orientation to support care collaboration. In a patient-centered medical neighborhood, specialty practices risk being relegated to the periphery, with patients' access to them restricted by primary care providers, if the specialists do not embrace a more population-based approach and provide better value. The success of the medical neighborhood rests on alignment between the medical home and its neighbors in their long-term goals for their shared patient population. One possible blueprint is the specialty analogue and complement to the PCMH concept: the patient-centered specialty practice (PCSP).

In March 2013, building on the success of its PCMH program, the NCQA established PCSP standards for specialty practices engaged in a patient-centered care

model (see box). These standards aim to reinforce care coordination, improve access to specialty care, reduce the use of unnecessary and duplicative tests, enhance communication, and measure and improve performance. Nationally, 64 organizations have enrolled as early adopters, and the first round of NCQA recognition has begun. Participating clinics come from diverse geographic areas and specialty backgrounds. Like Lego pieces of differing shapes, sizes, and colors, primary care and specialty clinics must have interlocking mechanisms with standard specifications. To that end, the NCQA standards have focused largely on care coordination: establishing referral agreements, having tracking systems and feedback loops for referral, defining key elements in referral responses, and keeping patients informed. Standardizing care coordination by using a single set of specifications for all specialties can improve connectivity not only vertically, between primary and specialty care practices, but also horizontally, among specialties.

The “remodeling” of specialty clinics to make them more capa-

Key Components of the Patient-Centered Medical Home (PCMH) and the Patient-Centered Specialty Practice (PCSP).*

Standards for the PCMH	Standards for the PCSP
Enhance access and continuity (20 possible points)	Track and coordinate referrals (22 possible points)
Access during office hours	Referral process and agreements
After-hours access	Referral content
Electronic access	Referral response
Continuity	Provide access and communication (18 possible points)
Medical home responsibilities	Access
Culturally and linguistically appropriate services	Electronic access
The practice team	Specialty practice responsibilities
Identify and manage patient populations (16 possible points)	Culturally and linguistically appropriate services
Patient information	The practice team
Clinical data	Identify and coordinate patient populations (10 possible points)
Comprehensive health assessment	Patient information
Use data for population management	Clinical data
Plan and manage care (17 possible points)	Coordinate patient populations
Implement evidence-based guidelines	Plan and manage care (18 possible points)
Identify high-risk patients	Care planning and support self-care
Care management	Medication management
Medication management	Use electronic prescribing
Use electronic prescribing	Track and coordinate care (16 possible points)
Provide self-care support and community resources (9 possible points)	Test tracking and follow-up
Support self-care process	Referral tracking and follow-up
Provide referrals to community resources	Coordinate care transitions
Track and coordinate care (18 possible points)	Measure and improve performance (16 possible points)
Test tracking and follow-up	Measure performance
Referral tracking and follow-up	Measure patient and family experience
Measure and improve performance (20 possible points)	Implement and demonstrate continuous quality improvement
Measure performance	Report performance
Measure patient and family experience	Report performance
Implement continuous quality improvement	
Demonstrate continuous quality improvement	
Report performance	
Report data externally	
Use certified electronic health record technology	

* Adapted from the National Committee for Quality Assurance PCMH and PCSP Standards (www.ncqa.org/PublicationsProducts/RecognitionProducts/PCMHPublications.aspx). Depending on the total points achieved, a practice is recognized as a PCMH or PCSP at level 1, 2, or 3. For recognition as a level 1 PCMH, a practice must earn a total of 35 to 59 points; for level 2 recognition, 60 to 84 points; and for level 3 recognition, 85 to 100 points. In addition, a practice must achieve 50% of the performance targets for all six of the “must-pass” PCMH elements (boldface type). For recognition as a level 1 PCSP, a practice must earn a total of 25 to 49 points; for level 2 recognition, 50 to 74 points; and for level 3 recognition, 75 to 100 points. In addition, a practice must achieve 50% of the performance targets for all five of the “must-pass” PCSP elements.

ble partners for primary care practices is the next logical step in delivery-system redesign. Although there are indications that the spread of PCMHs may reduce hospital admissions and emergency department visits in some contexts and populations, some

studies have shown little to no improvement in utilization or cost and only modest improvement in quality.³ One optimistic interpretation of these findings is that PCMH transformation is necessary but not sufficient for fundamentally changing health care,

particularly for patients with complex conditions who rely heavily on specialty and acute care services.

Care coordination, particularly for elderly and chronically ill patients, remains a daunting task for primary care providers and a substantial barrier to im-

proved efficiency and patient safety. The average primary care physician must coordinate care with 229 other physicians working in 117 practices.⁴ Yet surveys show that communication between primary care practitioners and specialists occurs only 35 to 81% of the time (responses depended on whether respondents were describing sending or receiving information and whether they were primary care physicians or specialists).⁵ Traditionally, care is considered to have been transferred to, rather than shared with, specialists when a referral occurs — a perception that results in fragmentation of care.

What will the ideal specialty practice in the medical neighborhood of the future look like? Although it may be tempting to model its structure on the PCMH, specialists play intrinsically different roles from primary care practices. Moreover, different specialties have different scopes of practice and different types of referral relationships. Specialties such as dermatology may be primarily consultative; cardiology and gastroenterology may focus on evaluation and treatment; oncology may assume a patient's care temporarily or permanently; and nephrology may manage a patient's care with primary care providers. Each specialty is also likely to be engaged simultaneously in multiple types of relationships with clinicians of different patients whose disease is at different stages. Although specialty practices, like primary care practices, need to build systems that ensure timely access and care coordination, their systems should also emphasize appropriate utilization of specialty care and management of high-risk popula-

tions, given the disproportionate influence that specialists have in these areas.

Although sharing accountability for quality and cost may be a reality in closed systems such as Kaiser Permanente, it remains an aspiration for the majority of U.S. health systems. Although primary care physicians have been growing accustomed to having their payment incentives structured around global costs, specialists are still predominantly reimbursed on a fee-for-service basis. Newer bundled-payment strategies are emerging but have had limited effects to date on the quality or cost of care. Moving forward, alignment between payments for primary care physicians and specialists will be required for accountable care organizations (ACOs) and systems that accept comprehensive bundled payments or other types of globally budgeted contracts.

Lessons from the managed-care era suggest that any successful effort to control costs will require the engagement of all physicians, primary care and specialist alike, and that primary care cannot be the only point of leverage. Payers and accountable systems will need to break down resistance to collaboration from specialists whose predominant incentives are based on procedures and volume. Appeals to better patient care should be front and center in campaigns to recruit specialists to the cause of improving population health; and payment reform that directly affects specialists' compensation will almost surely be necessary as well. For example, within ACOs, specialty-based subcapitation contracts may be desirable in order to hold specialists ac-

countable and improve the functionality of the medical neighborhood.

Effective integration of specialty practices into medical neighborhoods is likely to require several important environmental precursors. First, a sound infrastructure design can connect PCMHs to the spectrum of surrounding specialty practices. An aligned information architecture will be vital to adequate patient access, care coordination, and communication. Second, a patient-centered neighborhood will rely on an organizational culture that supports shared learning and transparency of performance and cost data among participating practices. Third, payment incentives will have to be aligned around shared accountability for outcome and cost. Responsibility for outcomes and total cost of care will have to rest not only with primary care clinicians, but also with specialists who perform (often expensive) procedures and specialty services.

The launch of the NCQA's PCSP recognition program is a sign of a new phase of delivery-system reform — a phase that seeks to involve providers who are less likely to benefit from reform in terms of either money or status. For some specialty groups — particularly proceduralists who have benefitted financially from the fragmented fee-for-service system — the adoption of systems and a culture that supports coordinated and cost-conscious care will be a hard sell. Active engagement of most specialties in a more patient- and population-centered model of care is necessary, however, and will require payers and systems to ensure that the status quo is no longer a

feasible option, while providing support and a compelling clinical rationale for change.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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DOI: 10.1056/NEJMp1315416

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Redesigning Surgical Decision Making for High-Risk Patients

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An 80-year-old nursing home resident has a colon mass and has been scheduled for a colectomy. Has he been told that 30% of elderly nursing home patients who undergo colectomy die within 3 months after the surgery and that 40% of the survivors have a significant decline in functional status, or that 12 months after surgery, half the patients have died and half the survivors have a sustained functional decline?¹

One third of elderly Americans undergo surgery during the last 12 months of their lives, most of them within the last month.² Yet three quarters of seriously ill patients say they would not choose life-sustaining treatment if they knew the outcome would be survival with severe cognitive or functional impairment.³ How many of these patients and their caregivers are offered less invasive options? How should such patients be counseled about the risks of complications and functional impairment after major surgery? And who should help them weigh the risks against the potential benefits of surgery?

The process by which surgical

decisions are made has remained largely unchanged since William Halsted's time. Typically, decisions are made after a discussion between a surgeon and the patient and perhaps the patient's spouse, partner, child, or caregiver. Other physicians — cardiologists, pulmonologists — are sometimes called in to provide clearance to pursue a planned procedure or for assistance after a complication occurs. This approach is deeply ingrained in surgical culture. Creating a trusting relationship with each patient is a key responsibility that society vests in surgeons and that surgeons consider central to their work.

Yet this approach may be sub-optimal for many high-risk elderly patients facing decisions about major surgery. Patients may not always be presented with all treatment options, including watchful waiting, medical treatment, less invasive surgical approaches, or percutaneous approaches. Patient-centered care means that patients make health care decisions in partnership with their physicians and that these decisions are driven by the patients' values and preferences. For some patients, quality of life

and autonomy may be much more important than quantity of life. A surgeon meeting a patient for the first time may not know that person's life circumstances well enough to fully understand his or her values and preferences. And as trained interventionists, surgeons may be biased toward aggressive treatment approaches. Although efficient, the traditional approach may be more physician-centered than patient-centered and may not always be respectful of a patient's wishes and goals.

Shared decision making in surgical care requires a culture shift. It means that patients are given the choice among treatment approaches (including no treatment), along with the information they need to understand the potential benefits of each option, the likelihood of a good outcome, and the risk of complications. For patients at high risk for adverse events after surgery, or in cases in which the balance of risks and benefits may be equivocal, the traditional surgery model may fall far short of the ideal. Evidence-based clinical decision making may require input from a multidisciplinary group of experts, as opposed to a "consensus of one."