

Refusing Our Default Future: Organizations That Are Accountable for Care Can Lower Costs and Improve Quality

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Models of health care payment and delivery are being rapidly transformed. In North Carolina, multiple organizations are involved in this redesign. Cornerstone Health Care has reorganized its care models and renegotiated its contracts in order to improve the quality and lower the cost of health care.

Everyone has a default future—the future we have if we just keep doing what we’ve been doing and passively accept what comes our way. The default future of health care in the United States is not pretty. The US health care system is too expensive, and outcomes and quality of care fall short of expectations. National health spending per capita now equals 30% of median income and consumes 18% of our gross domestic product (GDP) [1, 2]. Demand for health care services and the cost of those services continue to grow, driven by the aging population, declining health status, improvements in technology, and general medical cost inflation. Meanwhile, the supply of funding across all sources has reached a constraint point; Medicare insolvency is on the horizon, state Medicaid budgets are heavily limited, and employers are choosing not to offer coverage because of large increases in premiums. The growing gap between the demand for services and the supply of funds means that we cannot sustain the rate at which health care spending is increasing. Reductions in overall spending and a decrease in long-term growth will be required for sustainability of the system.

Fortunately, no one has to accept a default future [3]. We can eliminate our default future by choosing to redesign it—by creating a vision and a good strategy to get there. The logical place to start is with a redesign of the fee-for-service (FFS) payment model, which destroys value for all stakeholders. Under a FFS payment model, providers are paid based on the volume of the services they provide, not the value to the patient. FFS thus creates a disjointed health care system comprised of siloed sites of service, each operating as its own profit center, in which there is no intrinsic monetary incentive to coordinate services. Health care professionals are paid separately for the services they provide and are not incentivized to coordinate care with other health care professionals or institutions. Patients have difficulty

navigating a FFS system since their care is uncoordinated and each service is paid for separately. Payers have increasing costs, declining member satisfaction, and increased attrition. Physicians face constantly declining FFS payments and have no ability to fund the development of coordinated, evidence-based care models. Beneficiaries face increasing costs for poorer benefits and disappearing employer coverage. Employers pay higher premiums, which reduces their ability to pay competitive wages and to compete internationally. And society experiences a decline in health status, even as we invest a greater portion of our GDP in health care (and as a result are underinvesting in other important aspects of our economy, such as in infrastructure and education).

In 2010 Congress passed the Patient Protection and Affordable Care Act. Much of this legislation is focused on improving access to care through insurance reform and expansion of care for uninsured and underinsured individuals. A smaller portion of the legislation is focused on the redesign of the FFS payment system. In 2012 the US Supreme Court’s decision to uphold the Affordable Care Act reinforced strategic activities under way across sectors of health care. All of these new payment models have been lumped under the rubric of “value-based” payment systems, in contradistinction to the volume-based incentives in FFS care [4]. The value-based trend has gained momentum with commercial insurers and employers, and the Medicare Shared Savings Program, launched in April 2012, has further accelerated the creation of accountable care organizations (ACOs) across the country. Currently 45% of the US population lives in a primary care service area with at least 1 ACO [5], and there are now 441 identified ACOs across the country [6], including 8 in North Carolina [7].

Broadly speaking, an ACO is simply a group of health care providers who are organized in such a way that their reimbursement is based on how well they take responsibility for both the quality and the cost of the services they pro-

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vide. An ACO must bear financial risk for a defined population, coordinate and oversee the clinical provision of care across a continuum of health care services, and provide measured outcomes related to cost and population health. Accountable care can be facilitated by more than one type of organizational structure, including clinically integrated health systems, independent multispecialty medical groups, independent physician organizations, hospitals and their organized medical staff, and health plan and provider collaborations.

Throughout North Carolina, there are multiple examples of these models. Novant Health, which participated in the Centers for Medicare & Medicaid Services Group Practice Demonstration Project and recently announced an ACO partnership with Cigna, is an example of an integrated system ACO [8]. Cornerstone Health Care and Wilmington Health Associates are independent multispecialty medical groups that participate both in the Medicare Shared Savings Program and in ACO arrangements with commercial payers. The Triad Health Network, made up of Cone Health's employed and affiliated physicians, is an example of the organized medical staff model, whereas Key Physicians is an example of an independent physician association model. Finally, the partnership of Caldwell Memorial Hospital and its physicians with Universal American and the Medicare Shared Savings Program is an example of a payer-provider model.

The type of infrastructure necessary for an ACO to be successful differs considerably from that required for a successful FFS health care business. ACOs need new forms of governance and structure, care transformation support, financial analysis and reporting, operational support, information continuity and management, quality management, and network development and support; underinvestment in any of these crucial pieces of ACO infrastructure creates considerable risk in the new payment models. The American Medical Group Association has identified 7 aspects of a high-performing health system [9]. These include the efficient provision of services, an organized system of care, quality measurement and quality improvement activities, care coordination, use of information technology and evidence-based medicine, compensation practices that promote the 5 objectives just listed, and accountability. The association does not define a high-performing health system as a hospital with employed physicians, a multispecialty medical group, an independent physician association, a traditional hospital with its organized medical staff, or a large multihospital health system. Rather, performance is defined by the provision of value-based services.

Cornerstone Health Care is an independent multispecialty medical practice in the Piedmont Triad area of North Carolina, with more than 370 providers on staff at 15 hospitals that are part of 6 separate health systems. Its broad primary care base, comprehensive specialty coverage, and extensive outpatient ancillaries have allowed an integrated

approach to health care. Despite Cornerstone's success, the practice's physicians have concluded that the unsustainable nature of the current health care delivery system necessitates a transformative shift in their clinical and business model.

Cornerstone has made extensive progress in transitioning from a FFS organization to one that will be successful in a pay-for-value health care delivery system. It has done so by simultaneously transforming its care models and payer contracts and investing in new technologies, facilities, and human resources. Cornerstone developed a 5-pronged strategy for developing the capabilities required to become an ACO: It has focused on development of primary care medical homes, clinical integration across the spectrum of care, information integration, organizational realignment around service lines, and reimbursement-model transformation.

Medical home development began in 2007 with the first efforts at improving care through 3 programs developed by the National Committee for Quality Assurance: the Physician Practice Connections Recognition Program (which recognizes practices that use systematic processes and information technology to improve patient care), the Diabetes Recognition Program (which recognizes clinicians who use evidence-based measures and provide excellent care to patients with diabetes), and the Heart/Stroke Recognition Program (which recognizes clinicians who use evidence-based measures and provide excellent care to patients who have cardiovascular disease or have had a stroke). A broad range of capabilities began to evolve across the full care continuum, including clinical pharmacy services for anticoagulation management and diabetes management. Multiple practices in primary, specialty, and ancillary services began offering extended and weekend hours. Outpatient infusion services permitted the administration of intravenous medications and fluids 7 days per week. Patient-care advocates who were trained in customer service began using an analytic tool to identify high-risk patients who had experienced gaps in care and to reengage them with primary care physicians. Realizing that a true medical home is based not on recognition but on function, we are continuing to make efforts to improve care coordination, and we are integrating health navigation, team-based advanced practice providers, clinical pharmacy, behavioral medicine, and social work into care model design.

Clinical integration requires that high-impact specialty care models be integrated into medical homes to improve outcomes via better management of the full care continuum. The FFS model is replaced by a process in which the population is stratified by health status and condition in order to allow for categorization of patients based on their level of need for health care delivery resources. At Cornerstone, patients were risk-stratified into several categories—such as healthy adults, healthy adults with risk factors, adults with early chronic conditions, and adults with complex chronic conditions—and care models were designed accordingly.

Cornerstone followed a disciplined process to identify areas of opportunity and to quantify the potential impact of planned changes on each care model.

In late-stage and uncontrolled advanced chronic conditions, such as end-stage renal disease and congestive heart failure, an intensive focus on the individual patient's overall health delivery ecosystem can improve the management of care. Initially, high-impact specialty care models were developed for cardiology, oncology, and advanced primary care patients who have multiple complex chronic diseases or a single chronic disease with multiple comorbidities. Beyond the development of specific care models, Cornerstone instituted a number of targeted quality and value-driven initiatives in its key service lines, including implementation and tracking of prevention quality measurements in pediatrics; standardization of routine prenatal testing and annual tests around evidence-based guidelines in obstetrics and gynecology; coordination with primary care to create evidence-based imaging protocols in orthopedics; and guideline-based imaging protocols for lower back pain, migraine, and dementia in neurology.

Information integration is crucial to improving and measuring performance in an accountable care structure. Necessary technology capabilities include tools for financial and clinical risk management, care coordination, effectiveness analysis, patient safety, and patient engagement. In this early era of population health management, many of these tools are still immature. Cornerstone has chosen to use the best software and analytic tools available commercially and to augment these with homegrown solutions to improve population analytics and care coordination. A focus on reduction in waste, reduction in variation, and an increase in influence have permitted focused evaluation of technology. Data from a variety of sources, including claims and the clinical record, have been integrated through a data warehouse using a number of individual tools to create outcomes-oriented solutions for patient identification, patient engagement, care coordination, financial predictive modeling, clinical predictive modeling, and referral management. Clinical decision support tools are superimposed on the electronic health record, and provider performance reports and patient registries are beginning to improve processes. A technique called exception management can identify patients or provider care patterns that are outliers in order to analyze patterns of risk, costs, and gaps in care. This technique enables individualized attention to be given to those patients who may receive the most benefit from additional services. Clinical data science systematically analyzes patient data to look for opportunities to improve both the cost and quality of care provided to patients.

Organizational realignment is an ongoing effort that includes monthly clinical service line meetings, redesign of committees around quality improvement (which includes improving the patient experience and performance improvement), redesign of physician compensation, a focus on

patient safety and patient compliance, and broad investment in physician leadership. More than 40 physicians are compensated for taking leadership roles in the organization as committee chairs, senior administrative leadership, board members, or service line medical directors. All providers are compensated for attending service and committee meetings. These efforts have led to broad participation in the organization's transformational change efforts, which has permitted more rapid adoption of improvement efforts.

Cornerstone made the decision to move to value-based reimbursement as quickly as possible in order to align its investments in care model redesign and infrastructure with consistent payment models. As of April 2013, 100% of its commercial and governmental contracts have value-based reimbursement. All of these models are superimposed on a traditional FFS reimbursement model, but they include additional reimbursement for meeting quality and patient satisfaction performance metrics, and they offer substantial potential revenues for savings over predicted costs of care. This model, termed "gain-sharing," gives providers a portion of the savings, while returning the rest to the payer where it can be used to lower premiums for the patient. Ultimately, as Cornerstone continues to improve its care models and processes, we will have the ability to accept other forms of value-based payments such as bundled payments, global payments, or full-risk capitation.

Within the past 12 months, Cornerstone has aggressively renegotiated all of its contracts and has simultaneously developed multiple care models intended to provide higher-value care. These include the Personalized Cardiac Care Program at Carolina Cardiology Cornerstone, the Cornerstone Personalized Cancer Care Program, the Personalized Primary Care Program, the Cornerstone Care Outreach Clinic, and the Cornerstone Lifecare Clinic. The focus of each clinic is a specific at-risk patient group (congestive heart failure patients, cancer patients, patients with multiple complex chronic conditions, dual-eligible Medicare-Medicaid patients, or end-stage disease patients), but the redesign emphasis is similar for all of these programs: An integrated team of physicians, nurse practitioners, social workers, psychologists, care navigators, health coaches, and pharmacists work together to meet the needs of the individual patients.

The results of Cornerstone's redesign efforts are thus far unknown, although early data are promising. Cornerstone is currently tracking the total cost of care per patient, which is \$2,041 lower on average than the average cost of care for other participants in the Medicare Shared Savings Program. Since 2010 Cornerstone has received more than \$8.2 million from pay-for-performance incentive programs, and unpublished results of a national collaborative show that Cornerstone has more patients with on-target lipid levels than does any other participating group. In 2012 Cornerstone won the Success Story Award from Press Ganey for patient satisfaction. Access to care also continues to improve, with

visits on weekends and during extended hours increasing to 28,692 last year.

Regardless of the ultimate results of Cornerstone's efforts, in the current environment of an unsustainable FFS health care delivery environment, it is important to remember that survival depends on the ability to adapt to a changing environment. Without rapid change throughout our health care delivery system, significant problems await our nation. NCMJ

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