ISSUE BRIEF

Pivoting to Value-Based Care in North Carolina

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Health care in the United States, and by extension in North Carolina, is in a perpetual state of flux. From the Nixon-era predictions of runaway costs to the insurance-anchored efforts of Hillarycare to wide-sweeping reforms of Obamacare, established providers are regularly counseling the next generation on how different medicine will look when they are in practice. The accuracy of some of these predictions aside, one thing is sure: the pace and magnitude of change is palpably different this time. Pushed by both private and public payers to move from fee-for-service to value-based care while striving to meet the Triple Aim of improving patient experience, improving population health, and reducing costs, all arenas of medicine—hospital-based, ambulatory, and public health—are feeling the pressure. At the same time, patients are acting more like consumers, demanding transparency in pricing and increased quality.

In this issue of the NCMJ, experts from a broad range of backgrounds and health care organizations discuss the trials and rewards facing providers and health systems as they promise better outcomes and assume greater financial risk in care delivery. The ways that we are striving to meet new payment models—and the successes we are achieving—are as varied as the practices across North Carolina. In the following pages, you will read about the many efforts to implement these new models, both stories of success and a few cautionary tales.

Most North Carolina health care professionals are familiar with the aim to transition from fee-for-service to value-based care. Spurred by actions of the US Department of Health and Human Services, and followed closely by private insurers, new payment models and new reporting metrics will require keen focus on better care and better outcomes at a cost that, if not lower than current expenditures, at least bends the upward curve toward a more sustainable trajectory. Our colleagues from the Centers for Medicare & Medicaid Services (CMS) [1] provide a primer on the range of alternative models, most of which are addressed in this issue of the NCMJ, and the mechanisms by which these models will be implemented, evaluated, and incentivized.

The dyad of the physician-patient relationship is changing. Decreasing costs will certainly require each member of the medical team to operate at the top of his or her license. In a sidebar, Shock [2] explores the potential of team-based care in value-based systems, and she offers support for Bruch's [3] argument that smaller practices face additional challenges in implementing programs that can achieve these aims.

If we accept the definition of population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" [4], then individual providers and entire health systems are responsible for the health of a population, and new ways of addressing what goes on beyond the clinic walls are necessary. Petersen and colleagues [5] argue that it is time to re-engage (and increase funding for) public health, since public health agencies are better equipped to assess and address community needs. Specifically, public health agencies can provide expertise in social determinants of health and marshal efforts to improve the health of the entire population, not just those individuals who have insurance or seek care. In her description of accountable health communities, Harris [6] takes the argument one step further and explores how collaboration across multiple sectors creates a new system of health care. Harris' piece is particularly timely given the push by CMS to support accountable health communities [7].

In another commentary, Komives [8] gives us a history lesson, tracing the rise of insurance from the first groups nearly 2 centuries ago, through the first health maintenance organizations of the 1940s, and into the present. She cautions us against repeating the mistakes that caused the rejection of managed care in the 1990s and offers ways that providers, as opposed to payers or legislatures, can be more involved in bending the cost curve while improving performance. She reminds us that, while the forces of change have evolved over time, one thing has not: the provider's "power of the pen."

Tracing the history of one North Carolina multispecialty medical practice, Terrell [9] discusses how her practice moved all contracts to a value-based, accountable care organization (ACO) model, with positive outcomes in quality and cost. On the other hand, Bruch [3] describes how bundled payment programs are better suited to specialist

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physicians, and he offers insight into how current state and federal reform initiatives present challenges for independent practices.

Developing new models is particularly challenging in rural areas, as Willis [10] describes. As one of the original Medicare Shared Savings Program ACOs, the Accountable Care Coalition of Eastern North Carolina achieved enviable results in terms of reducing preventable admissions and readmissions in its first 2 years of operation, but it was unable to achieve significant shared savings. This coalition's experience offers valuable insight for everyone considering entry into the ACO arena.

One important component of value-based metrics is the patient experience, as measured both in outcomes and in patient perspectives. Wegner [11] discusses the metrics used, or proposed, in quality reporting. He further builds on Bruch's [3] argument, explaining how bundled payments can be extended to a variety of clinical conditions.

In another commentary, Wynn [12] addresses the patient experience from another angle, arguing that effective patient engagement equals better clinical outcomes. She describes the ways in which patients are becoming more effective consumers of health care. The consumer-driven model has the potential to, over time, enhance our efforts to improve population health.

Using data to improve population health—and to demonstrate that improvement—is a challenge faced by all members of the medical community. Community Care of North Carolina (CCNC) has extensive experience in using data to improve the health of North Carolina's Medicaid recipients. In her Running the Numbers column, DuBard [13] points out how CCNC has used analytics to help providers across the state reduce overutilization and costs and improve outcomes and satisfaction.

The patient-centered medical home (PCMH) is perhaps the oldest and most widely used model that demonstrates improved quality at lower costs [14]. Describing a PCMH pediatrics practice in Goldsboro, Tayloe [15] acknowledges that practices must be nimble and responsive, since further change is virtually guaranteed. Similarly, Fields [16] describes how the PCMH process—of evaluation, measurement, and improvement—is similar to the process required for value-based care. Caveney [17] also outlines the ways that Blue Cross and Blue Shield of North Carolina has supported physicians in the move to PCMH and ACO models.

My own experiences—both as executive director of the Duke Health and local community ACO, Duke Connected Care (DCC), and my clinical practice in a PCMH—echo those of my colleagues who are contributing to this issue of the NCMJ. DCC is aiming to develop broad and deep competencies across multiple disciplines required for population health improvement. Duke is home to the Duke Clinical Research Institute, the Center for Population Health Sciences, the Duke Institute for Health Innovation, the Margolis Center for Health Policy, and Northern Piedmont Community Care (a CCNC network), all of which are positioned to test theories of quality improvement against large claims data sets and to develop and assess applications for improved outcomes. As one of the largest ACOs in North Carolina, with 2 value-based contracts accountable for more than 65,000 lives, DCC treats patients with a wide variety of clinical needs. Many patients come to Duke for heroic care, and the richness of experience at Duke's ACO is one reason that many patients with complex medical needs seek care here.

Bringing those resources together is challenging. We are learning from others and bringing together disparate groups who would not likely interact in the old business model of medicine, and we are working to discuss issues that will directly impact care. Also, we are supporting primary care and specialty providers in their efforts to achieve the triple aim and to succeed in new models of care and payment. We are delivering on quality, particularly given the complexities of our patients' needs. The benefits to the institution as a whole are profound and far-reaching.

The responses by some individual physicians and health systems to the shifting landscape are not unlike the 5 stages of grief. But to ensure success in new models of care, the medical community must move beyond acceptance to assume primary responsibility in directing the process. This issue of the NCMJ points the way. NCMJ

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