A Modified "Golden Rule" for Health Care Organizations

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See also pages 707, 710, 714, 721, 723, 727, 729

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Partners HealthCare (Partners) is an integrated health care delivery system in Boston, Massachusetts, that includes 2 large academic medical centers—Massachusetts General Hospital and Brigham and Women's Hospital—with more than 6000 physicians, including more than 1200 primary care physicians. In November 2011, Partners leadership agreed to become a Pioneer Accountable Care Organization (ACO), placing a significant fraction of their revenue at risk in a contract with the Centers for Medicare and Medicaid Services (CMS) that encourages them to hold increases in medical expense trend below the national average. Given our negative experiences with capitation in the 1990s, the decision to participate was largely based on 4 factors that differentiated the current environment and agreement terms from our prior experience.

First, efforts to reduce health care spending as a percentage of gross domestic product are likely to persist. Unlike in the 1990s, the extent to which current health care expenditures are crowding out other important programs is unsustainable. Accordingly, state and federal governments are taking a proactive role in cost-containment efforts. Second, the preservation of patient choice (as opposed to the closed networks of the 1990s) somewhat mitigates the "physician as gatekeeper" tension that contributed to the demise of capitation. Of course, this new twist also makes taking financial risk less appealing, but under the right conditions, the trade-off seems reasonable. Third, the threshold for achieving shared savings is to increase spending at a rate that is less than the national average. Such a moderate approach seems more reasonable than the steep discounts negotiated by commercial payers in the 1990s and is consistent with the scale and pace of change that will be required for success. Finally, Partners is better equipped to care for populations of patients today than we were in the 1990s. A universally adopted electronic health record, improved communication and notification tools, and real-time data tracking of patients as they move within our organization permit more precise and proactive management of quality and costs. In addition, we are better able to provide feedback on health care professional–specific variation to our physicians as part of our efforts to promote continuous improvement.

What do we plan to do differently as a Pioneer ACO? Our plan includes 3 distinct but mutually reinforcing activities: (1) managing how financial incentives flow through our system, (2) implementing programmatic initiatives for managing cost and quality trends for our primary care population, and (3) demonstrating value to other ACOs that are referring their patients to us.

Incentives

When considering incentives, the 1990's lesson is not to push budget-based risk all the way down to the individual health care professional. Such an approach puts physicians in an untenable position regarding decision making for the care of their patients.[1] In an effort to mitigate this problem but also ensure that physicians have an incentive to manage care efficiently, we will pass financial risk to large groups of physicians (typically more than 50 and salaried) using an internal performance framework (IPF). Our IPF includes rewards for adopting programmatic initiatives (see Programmatic Initiatives for Managing Populations), meeting external quality measure targets, and limiting the growth of cost–standardized medical expense trend. We used a cost-standardized approach to provide an incentive to keep care integrated within the organizational members of our delivery system. In the cost-standardized approach, primary care physicians are incentivized to refer patients within our health care delivery system, where we can control costs more efficiently. The IPF includes our specialists who were largely left on the sidelines (under discounted fee-for-service) during the 1990s. The IPF unites our specialty and primary care physicians with a common goal: to provide optimally efficient care.

Programmatic Initiatives for Managing Populations

The Figure shows the 20 tactics Partners has identified as important for improving quality and decreasing costs. We envision successful care redesign tactics along 3 core elements of care delivery: (1) providing access to high-quality care, (2) redesigning care to be more effective and more efficient, and (3) measuring our performance. Within our care redesign framework, each of these core elements falls into 1 of 3 settings in which care is actually delivered: primary care, specialty care, and hospital care.

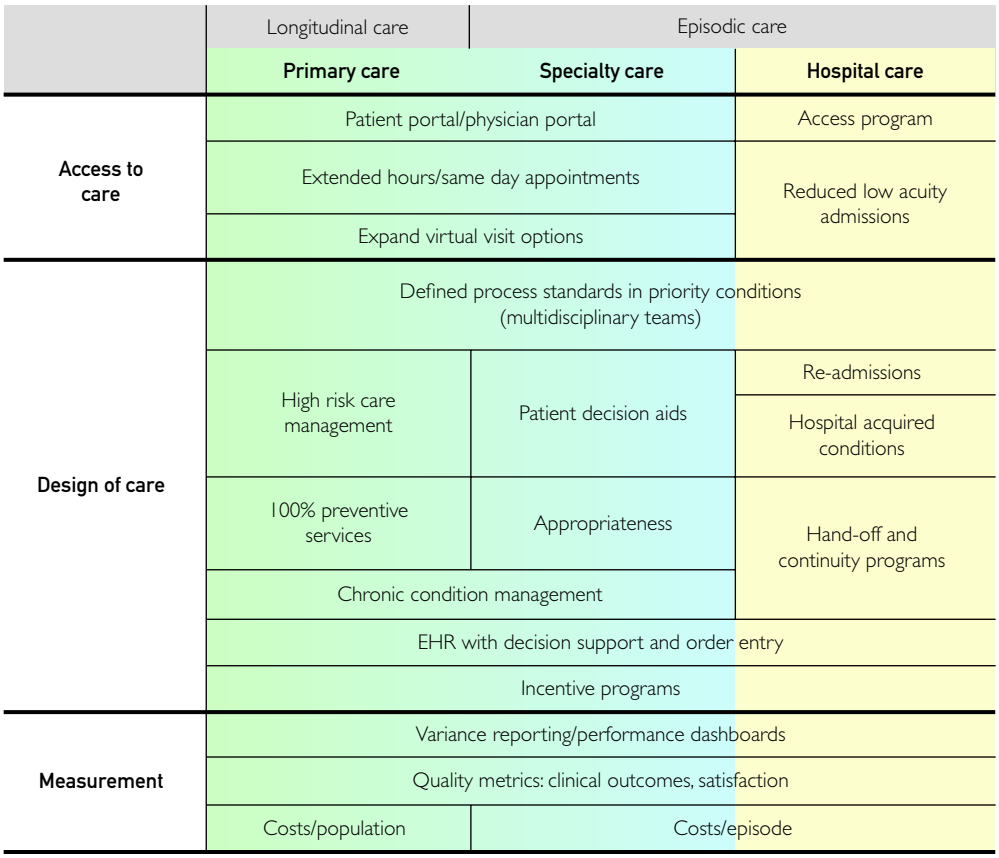

FIGURE. Evidence-based care improvement tactics.

While not shown on our tactics table, home care and postacute care are very much a part of this redesign framework and essential for integrating care across the continuum.

Several of our initiatives address access. A bidirectional Internet-based patient portal allows patients to access their medical records, request prescription renewals and referrals, make appointments, and communicate with physicians. This technology has demonstrated effectiveness in reducing unnecessary physician visits.[2] Partners also measures and reports back to practices their patient access, encouraging local efforts to extend office hours and offer same-day appointments. Some Partners sites have initiated paying primary care physicians a portion of their compensation on the basis of risk-adjusted panel sizes to encourage more effective and efficient team-based care. This helps get primary care doctors off the relative value unit "hamster wheel" and frees up time to work with care managers and manage patients by phone and Internet. This in turn frees up capacity in the office for patients who need urgent face-to-face visits. Finally, our telemedicine programs are building capacity to conduct more virtual visits, reducing the need for patients to travel in situations that do not require it and at the same time reducing our cost trend.

While these access-related initiatives are important, our program for high-risk patients is critical to our success in managing trend in a Medicare population. It is well known that Medicare spending is concentrated in a relatively small fraction of high-cost beneficiaries.[3] In 2006, Massachusetts General Hospital began a 3-year CMS demonstration project focusing on high-cost Medicare patients. The intervention relied on the assignment of a nurse care manager to each of the identified patients and leveraged information technology systems to track and communicate real-time changes in patient status and care plans. Each physician's care manager worked directly with them in their offices. Outcomes after 3 years included a 20% reduction in hospital admissions, 4% lower mortality rates, and approximately 7% net cost savings. In 2009, the CMS extended the demonstration for an additional 3 years and expanded the scope to additional Part-

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ners institutions. A recent Congressional Budget Office analysis found this intervention to be the only CMS care coordination demonstration that showed statistically significant improvement in cost trend.[4]

Another key aspect to improving quality and lowering cost trend is providing our patients with enhanced access to specialists. Specialists and the tests and procedures they perform account for nearly 50% of spending in a commercially insured population. We anticipate providing rapid access to our patients for a subset of specialty services through nonbillable on-site and telemedicine processes.

Constantly measuring and improving our performance is another important tactic. Providing meaningful performance variation data to physicians is challenging, but our experience suggests that this is both practical and effective. Our hospitals have implemented computer-based electronic order entry systems with decision support.[5,6] Use of this system allows both immediate feedback as well as data collection and feedback of comparative data on test ordering. We also distribute comparative data in medication ordering and the use of some services. We plan to dramatically expand the number of clinical areas for which we provide reports as well as the number of clinicians who receive these reports.

Demonstrating Value to Referring ACOs

The previously described tactics make sense for managing a population, but most of the patients seen within an academic medical center are referred from nonaffiliated physicians. If these referring physicians are themselves in an ACO, we will need to make sure that they view us as the tertiary provider of choice. How will we do this?

Partners has begun redesigning the process by which patients receive care for individual conditions. Multidisciplinary teams gather to rationalize the steps in the delivery of a service from the patient's perspective and with an eye toward improving efficiency. We started with diabetes, acute stroke, acute myocardial infarction, coronary artery bypass grafting, and colon cancer. Each team provides recommendations to improve patient-centered outcomes while reducing the cost of providing those outcomes. Within episodic specialty care redesign, we are focusing on some core elements, including (1) patient decision aids, (2) documentation of appropriateness, and (3) decision support and order entry in the electronic health record. Finally, using our network of community hospitals, post-acute care settings, and home health care, we are moving patients with less complicated health problems to community settings when this is appropriate and more convenient for patients.

Conclusion

We view the work described herein as pushing the limits of what can be expected of health care organizations, but success as a Pioneer ACO will depend on additional factors outside our control. Under the new rules of provider risk, our patients can choose to receive their care within our system or somewhere else. Obviously, we cannot control quality or costs of care outside our system, so we will work to demonstrate to our patients that they will receive the best care if they choose us. In addition, the Pioneer ACO does not appear to provide a mechanism to reduce the very high administrative and regulatory costs in our system.[7] Finally, we do not control the benefit design, so we have limited leverage when patients seek covered services that provide little or no benefit.

The path we have started down is ambitious. However, engaged health care organizations that want to be part of the solution should make the changes to the delivery of care in the way they themselves would want to be treated as a patient. The Golden Rule states that we should do unto others as we would have them do unto us. In considering the extent to which the numerous non–health care organization stakeholders in health care would dictate the terms under which care is provided, we have modified this rule. In order to define a future best suited for patient care, health care organizations should do unto themselves as they would have others do unto them.

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