CSB CASE STUDY BRIEF

Designing an Extensivist Model for High-Needs Patients

Cornerstone Health Care's Approach

Domain: Patient Centeredness
Category: Ease of Use
Competency: PC.1.3 Provide convenient and timely access to care and care information based on needs of patients

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BACKGROUND

Since 1995, Cornerstone Health Care has been at the forefront of care delivery innovation, aligning its mission, vision, and values with the six aims of health care quality set by the Institute of Medicine. As part of this alignment, in 2010, Cornerstone began making simple changes to increase patient access to care. However, the medical group quickly realized that meaningful, long-term improvements would require significant changes to the group's care management programs. Consequently, in 2012, Cornerstone deployed five care models, designed to follow best practices identified in the literature and from past experience. The redesigned models focused on improving care for patients with 1) high-risk complex conditions, 2) cancer, 3) late-stage congestive heart failure, 4) Medicare-Medicaid dual eligibility, and 5) five or more chronic diseases. This case study details one of Cornerstone's most successful models, targeting high-risk complex patients, known as the Extensivist Program.

About Cornerstone Health Care

Cornerstone is a multispecialty medical group with more than 330 physicians and advanced practice professionals in 80 locations. In 2013, the group formed Cornerstone Health Enablement Strategic Solutions (CHESS), which partners with Cornerstone and other providers to support the move toward value.

Location: High Point, North Carolina
Website: www.cornerstonehealth.com
VBP Activity:

- Cigna since April 2012 (later migrated to CHESS)
- MSSP Track 1 July 2012 to Dec 2014; rejoined Jan 2015 (later migrated to CHESS)
- UnitedHealthcare since January 2013
- BCBSNC since May 2013
- NGACO since Jan 2016 (CHESS)

APPROACH

The Cornerstone Extensivist Program improves the quality of life, functionality, and independence of the medical group's sickest elderly patients. A specialized care team consisting of an internal medicine physician, nurse practitioner, clinical pharmacists, RN patient navigator, and social worker provide comprehensive care to elderly patients at a standalone facility called the Personalized Life Care Clinic. The program emphasizes accountable high-intensity care that addresses both social and medical needs.

The Extensivist Program focuses on patients with multiple chronic conditions, high tertiary care costs, and socioeconomic barriers to improved health. Potential candidates for the program are identified using utilization data and multiple comorbidity indexes (e.g., the Optum Impact Pro risk stratification scores, the Charlson Comorbidity Index, and the Lightbeam Ability to Impact score). Potential patients must also live within 20 miles of the Personalized Life Care Clinic. Once identified, patient care costs and comorbidity indexes are shared with the patient's PCP, who determines whether to refer the patient to the Extensivist Program. Hospitalists and specialists may also refer patients not identified by the data. Cornerstone has found that this approach targets the right population, while also involving physicians in the decision. Patients are more willing to participate when referred by their PCP.

Once a patient is referred to the program, the RN patient navigator or the clinical pharmacist conducts an extensive phone interview with the patient to identify barriers to improved health and to schedule an appointment with the care team. To ensure that all patients can be seen within 1-2 days, the care team's panel does not exceed 200 patients. This small panel size also allows the team the flexibility to visit patients at home when necessary.

During the first appointment, the care team collaborates with the patient and other caregivers to complete a comprehensive health assessment. As part of the assessment, the physician reviews the patient's medical record–including all diagnostics and imaging results–to objectively confirm each diagnosis. The clinical pharmacist reviews the patient's medications and supplements for adverse drug-to-drug or drug-to-disease interactions by conducting brown bag medicine reviews and contacting local pharmacies. The careful review by both the physician and pharmacist ensures that the care team fully understands the patient's medical needs, as many of these patients do not realize the severity of their conditions when entering the program.

It is equally essential to gather complete information on the patient's broader needs. For example, the patient's literacy level, ability to pay for care, access to transportation, and exposure to domestic or substance abuse affect his or her ability to follow care regimens. Once non-medical needs are identified, the care team social worker collaborates with patients to address these needs, such as by helping patients manage their emotional state, linking patients with community resources, and helping patients finance their care.

Patients remain in the Extensivist Program until their condition has stabilized. The care team ensures that patients understand their medical conditions, and create plans to reach patient health goals. While a patient is in the program, the team provides on-going whole person care that is responsive to patient needs, such as answering questions by phone, coordinating care with specialists, and engaging in patient advocacy.

RESULTS TO DATE

An analysis of individuals enrolled in the Extensivist Program for at least three months between August 2013 and May 2014 showed that participation in the program reduced the cost of care by 10.7%, with inpatient hospital costs decreasing by 13% and outpatient costs decreasing by 19%.[1] In the prior year, the average spend per person was $51,289, which decreased to $45,815 the year of the study. However, because the study only included a sample of 56 Medicare patients and no commercial patients, Cornerstone plans to continue to evaluate the program in the coming years. Anecdotally, Cornerstone has observed high patient and caregiver satisfaction with the program. This is due to a number of factors, including improvements to patient functional status and self-care abilities, reductions in the number of medications and slowed disease progression, which lead to improved quality of life.

TOOLS & VENDOR PARTNERS

When implementing the care model, Cornerstone consulted with Oliver Wyman to outline essential program components, such as the care team composition, clinic design, and clinic location. Cornerstone felt that Oliver Wyman's direction was crucial to the program's success. Optum and Lightbeam have also been important partners, providing the necessary analytics to identify patient candidates. While these tools are valuable to the Extensivist Program, they were purchased as part of Cornerstone's broader infrastructure.

CHALLENGES WITH IMPLEMENTATION

Cornerstone's greatest challenge implementing the Extensivist Program was funding. While the program decreased the overall cost of care, it increased costs in certain categories. For example, the cost of office visits increased by 17%. Cornerstone did not have risk-sharing or capitation contracts with all of its payers, which made paying for the increased costs difficult. As a result, Cornerstone was forced to exclude services from the Extensivist Program that could have increased its effectiveness, such as providing patient transportation, and eliminating copays for office visits, specialty referrals, and mental health care.

Cornerstone also struggled to define the criteria for identifying patients for the program. For example, Cornerstone found that some patients in the program were more appropriate for hospice care. After refining the identification process over the past three years, Cornerstone feels that its current criteria targets the right high impact patients. Because the program is open to physician referrals, there will always be some patients who don't meet the program criteria. However, Cornerstone believes that accepting physician referrals is important for building trust and physician buy-in.

KEY LEARNINGS

- **Divide and conquer** – Design customized care management models around targeted patient care needs.
- **Seek sustainable funding** – Secure contracts that allow flexible care investments and that reward long-term outcomes as soon as possible.
- **Prioritize high-impact patients** – Determine the target population and test methods for identifying those patients.
- **Build strong teams** – Gather multidisciplinary clinicians with unique expertise but a common commitment to high quality care.

1 Green Dale E., MD MHA, Hamory Bruce H., MD FACP, Terrell Grace E., MD, MMM, FACP, FACPE, and O'Connell Jasmine, MHA. Population Health Management. January 2017, ahead of print. doi:10.1089/pop.2016.0105.

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