COPE HEALTH SOLUTIONS

Aligning Health Care Around Creating Value for Patients


Authors: Andrew Moore, Senior Consultant, and Dawn Johnson, Executive Vice President

An organization's strategic vision and plan are more than just an exercise for the board and executives. Done correctly, and focused on the right areas, they provide a roadmap for transformation and position the organization for future success. Strategic plans need not be overly complex to be successful, nor viewed as an overwhelming task. Thinking critically about your organization is key, but also key is understanding healthcare is experiencing a fundamental shift. Any plan must be underpinned by a value-based health care delivery model focused on *creating value for the patient*.

Today, provider organizations need to understand how to navigate the changing regulatory environment, operate with fewer resources and accomplish better outcomes, quickly. Michael Porter proposes a model, the Value-Based Health Care Delivery framework, with which organizations have experienced success. The framework shifts the focus of health care organizations to a more macro level: **creating greater value for patients**, instead of focusing on more discrete areas (improving access, controlling costs or providing a better patient experience). This includes the development of Integrated Practice Units (IPUs). By changing the focus to value creation for the patient, Porter argues the goals of all parties (the patient, the payer, and the provider) become aligned, thus reforming the system.[1]

In 1996, the University of Texas MD Anderson Cancer Center in Houston underwent a transformation in their approach to patient care. The idea was to change the way their providers delivered care, using an interdisciplinary center model.[2] Similar to the IPUs proposed by Porter, MD Anderson reorganized their providers, clinicians and support staff into disease/disease-site specific centers

[1] http://www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx
[2] Porter, Michael E., and Sachin H Jain. "The University of Texas MD Anderson Cancer Center: Interdisciplinary Cancer Care." Harvard Business School Case 708-487, May 2008. (Revised February 2013.)

structured as multidisciplinary outpatient clinical centers, specialty centers or diagnostic treatment centers, with very positive results. MD Anderson has been named one of the nation's top two hospitals for cancer care in U.S. News & World Report's "Best Hospitals" survey every year since the survey began in 1990, and the leading cancer hospital for 11 of the past 14 years. The importance of this statistic is that providers have been able to deliver more value through quality by deepening their expertise, and expanding their ability to serve the complex and interrelated needs of each patient over the full continuum of care.[3]

The Value-Based Health Care Delivery framework contains six fundamental components, which create the strategic agenda for shifting to a high-value healthcare delivery system as a whole– patients, providers and payers included. However, there are two key concepts embedded within it that are critical to a healthcare provider organization's strategic plan in order to be successful in today's shifting healthcare landscape: care delivery integration and information technology.

Vertical Care Delivery Integration

The enactment of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) created the Quality Payment Program (QPP), which essentially has two models for reimbursement for Medicare patients:

- *Merit-Based Incentive Payment System* (MIPS) measures quality, resource use, clinical practice improvement and meaningful use of certified electronic health record (EHR) technology.
- *Alternative Payment Models (*APMs) structure how providers are paid for treating Medicare beneficiaries through arrangements such as Accountable Care Organizations (ACOs), Patient Centered Medical Homes and bundled payment models.

Even prior to the enactment of MACRA, industry trends have been progressing toward greater collaboration and more consolidation in response to cost pressures. Hospital reimbursement has trended toward value-based payments from government and private payers, forcing hospitals to increase attention on quality of care (e.g., reduction of hospital-acquired diseases/infections, fewer readmissions, etc.). Primary care settings have become a gateway for many individuals with co-occurring behavioral health and primary care needs, whose diagnoses make them more likely to be hospitalized and readmitted. Overtime, organizations have realized that horizontal integration is an ineffective strategy to control costs, improve margins or provide more consistent, higher quality care. Healthcare provider organizations will need to integrate services vertically to support patients through the lifecycle of care, akin to Porter's IPUs arranged around medical conditions as opposed to the traditional provider organizational structure by department and specialty, which provide more value to the provider instead of the patient.

Benefits of vertical integration include leveraging existing, leading services through strategic partnerships to expand best practices and improve protocols. Using this approach, they are able to widen access to excellent care to a larger base, and allow the organization to focus resources on service lines and offerings that are areas of strength and expertise. This effective outsourcing of some services is a new and challenging concept for healthcare providers, but makes sense from a business perspective—differentiate by doing what you are good at, and acknowledge what you are not doing well. This will be more valuable to your patient population, and is more valuable to payers as well.

[3] Porter, Michael E., and Thomas H. Lee. "The Strategy That Will Fix Health Care." Harvard Business Review 91, no. 10 (October 2013): 50–70.

Information Technology

Technology advances in supporting healthcare providers have made large strides in the past decade, and were significantly accelerated with the enactment of the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009. The objective of this act was to promote and expand the adoption of health information technology (HIT). The idea was that unilaterally motivating and supporting provider organizations with an HIT platform would enable greater population health management, supporting patient safety and quality improvements. What we have seen is that a foundation has been set, but there is still work to be done to make HIT platforms truly functional and effective. An enabling HIT platform that support programs, initiatives, care, and communication is imperative, in addition to interoperability between platforms and systems. Electronic health records (EHRs) largely focus on three of the six quality of care dimensions: patient safety, effectiveness, and efficiency[4], but vary in the degree to which they have been useful in achieving these, and have been even less consistent in achieving equitability, timeliness, and patient-centeredness.[5]

Key to an effective HIT strategy centers on an organization's ability to share data, both internally and with external partners, affiliates, and non-contracted organizations while maintaining protected health information. Currently, data is not easily exchangeable across EHRs, or even between different instances of the same vendor's software, but demand for data-driven decisions and metrics that measure value is pressuring software vendors to develop viable solutions.

Similarly, provider organizations are beginning to understand the impact of decisions made during their haste to implement systems and capture the available incentives; even within organizations, there may still be tremendous inefficiency and inability to effectively exchange data. Moving toward an integrated care delivery model will require that organizations address these information exchange issues, taking actions such as further system or vendor rationalization, or system optimization to address installation or system build and configuration gaps and inefficiencies. Inefficiencies divert provider organization resources away from delivering and creating value for patients, and are often times a large source of frustration for patients and providers alike, diminishing value.

Another area of focus with HIT that shows tremendous value-creation potential is telehealth or telemedicine. Currently, telehealth is not widely used among providers because payers restrict reimbursement to specific patient populations in rural areas only, though CMS has approved a provisional (CPT code) that allows providers to bill for non-face-to-face care coordination services for Medicare beneficiaries. As collaboration between organizations, patients and providers continues to develop, we will see telehealth as another essential HIT tool at the disposal of the industry that has much greater potential to positively impact the quality of patient care and enable population health management efforts. In addition to the inherent value patients would see in this technology flourishing, there is tremendous value-add potential to both provider organizations and payers, such as ability to communicate and exchange data more efficiently—creating value for the patient translates to benefits across the continuum.

In addition to an enabled HIT platform facilitating information exchange or better patient care, is the power an effective HIT strategy has to provide the appropriate information for reporting purposes to various governing and regulatory agencies. Measuring costs and outcomes provides a gauge for

[4] Menachemi, Nir, and Taleah H Collum. "Benefits and Drawbacks of Electronic Health Record Systems." Risk Management and Healthcare Policy 4 (2011): 47–55. PMC. Web. 3 June 2016.

[5] http://www.ihi.org/resources/pages/improvementstories/acrossthechasmsixaimsforchangingthehealthcaresystem.aspx

determining how well an organization is doing improving the population health. Understanding which metrics housed within EHRs, for instance, will provide the outcomes measurements institutions such as CMS or CHHS in California require to demonstrate quality improvements, as systems are refined through process improvements or optimizations to documentation tools, provider organizations will be best positioned to respond.

What the patient values is quality of life during and after care cycles, including incidence of complications, and certainly survival. As patients become more savvy consumers and comfortable technology, expanding options already in use in some capacity, and leveraging existing technology and capability for exchanging information with payers and regulatory agencies, again, value creation for the patient leads to inherent value for all.

Key Takeaway
As you work to redefine your strategic vision and plan, consider the impact incorporating these two focus areas could have on both your short- and long-term success. The concepts are not complex, and the message is clear: a patient-centered approach focused on creating value is a winning strategy for redefining your organization, and potentially the industry as a whole.

About COPE Health Solutions
COPE Health Solutions is a health care consulting firm that advises hospitals and health care systems on strategy, population health management, Medicaid waivers and workforce development solutions. COPE Health Solutions provides clients with the tools, services and advice they need to be leaders in the health care industry.

For more information, please contact info@copehealthsolutions.org.