Volume 4, Issue 1 January 2017

Population Health NEWS

Meeting Consumers' Demands in Safety Net Health Systems

by Cindy Ehnes, Esq.

Fee-for-service medicine is often tagged as the culprit in fostering a fragmented, inconvenient, costly health system. These costs of inconvenience, poor system quality and high hidden expense impact every individual patient and healthcare consumer. In addition, many commentators believe that the healthcare system revolves around what's most convenient for physicians and other caregivers, as opposed to the actual healthcare consumer.

Consumers well understand what they want and expect from their interactions with the health system—low-cost, high-touch and convenient, community-based care. While well-heeled health systems are better equipped to deliver on these increasing consumer expectations, safety net systems are greatly challenged in accessing needed capital and risk-based contracts from payors to reward strategies that reduce inpatient revenue and require large-scale, infrastructure build.

Under the current administration, the Centers for Medicare and Medicaid Services (CMS) and other policymakers have been making macro moves to push health systems to improve quality, enhance the patient experience and lower healthcare costs. CMS has advocated that health systems move into risk-bearing relationships with payors to incent higher quality, less costly care. Given continued cost pressures, the federal push for enhanced quality and patient experience, with costs controlled under capitation or a similar value-based, payment framework, is likely to continue under the new administration.

A similar push for change is coming from consumers—both as patients and as payors for health services. Consumers have enough financial "skin in the game" to rightly question why health insurance and health services often lack basic service standards that govern most of their retail experiences.

Here are the top five things that healthcare consumers want clinicians and health systems to deliver besides good care:

1. **Treat me as an individual, not as data**. Patients want adequate time with clinicians to get at the heart of physical and emotional issues. When patients come to a visit with a binder full of information about their anticipated diagnosis, they hope to be seen as engaged partners with their health professionals. Comprehensive care management is a team sport, and consumers want to be a part of a team.

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2. **Don't surprise me with poor coverage and balance bills.** Consumers want their private or public coverage to provide predictable and affordable costs of care. This necessitates comprehensive health coverage because unlike auto coverage, in which risks of an accident and severity are statistically well-grounded, it is virtually impossible to predict one's health needs down the road. The majority of Americans are not financially prepared for the devastating monetary impact of chronic conditions, major accidents, disabilities or major medical events. That is why the Affordable Care Act's standardization of essential benefits coverage is vital from the standpoint of most insurance regulators. Consumers want reasonable bills and don't want surprises, such as balance billing by non-contracted personnel when they access an emergency room.
3. **Envision care from my eyes.** Consumers want innovation and ease of doing business, including use of mobile technology to personalize care. This includes extended hours for urgent care services, walk-in access for routine care and scheduled appointments. They want virtual visits and the ability to get lab results and order pharmacy services online. Consumers want clinical integration with system reminders at the point of care. They do not want to see a physician who is still using paper charts, requiring patients to carry photocopies of their medical records to a specialist.
4. **Don't fence me in.** Consumers want all the benefits of an integrated system without actually being in a closed network. Consumers instinctively love the word "choice" even though it has largely brought them disconnected, fragmented health services. Integrated delivery systems meet those expectations, comprised of robust panels of primary and specialty physicians, including behavioral health, linked organizationally and electronically to quality hospitals, clinics and community care.
5. **Help coordinate this bewildering healthcare cosmos.** Disconnected care puts the onus on the patient to figure out how to link providers, understand differing diagnoses and reconcile multiple medications. A care delivery system that focuses on and coordinates the care of the highest risk patients should be a reasonable expectation of consumers.

It's easy to rattle off the above list of an empowered consumer's demands. What many, if not most, of these "wants" have in common is patient centeredness and a very clear expectation of a more seamless healthcare experience. While often at odds on many issues, consumers and health plans share an abiding belief that high-quality, high-performance care should be a core capability of a system, not an expensive add-on.

But as experience has shown, health systems differ widely in their capabilities to transform the healthcare experience. All systems are facing reduction in hospital patient revenue, the staple component of hospital system budgets; however, many safety net systems serve the sickest and most means-challenged patients.

For many safety net hospitals, a majority of their patient population is covered by Medicaid, has been uninsured and/or homeless, is comprised of racial and ethnic minorities and tends to have more complex health and behavioral health issues. A quality consumer experience in this unique context takes on an enhanced scope that extends well into the community through ties with community-based organizations meeting social, behavioral, housing and economic needs.

To maintain or increase bottom line, financial performance while also improving quality and patient experience, many safety net health systems flirt with a risk-based, contracting strategy, in which payors will hopefully financially reward cost reductions and improved patient experience. These health systems often take some steps to build an appropriate supporting infrastructure toward population health management; however, the same systems generally maintain their clearest footprint on a discounted fee-for-service path, which relies on inpatient revenue.

This muddled strategy is both understandable and likely inescapable without a clear roadmap. Often it is based on magical thinking, "If we build it, they (payors) will come and reward our efforts." However, if the contracts with payors are not in place from the outset, the upfront costs of building a data or care management infrastructure are not supported by a payment stream and potentially reduce traditional sources of revenue. If health systems are not rewarded for these "big-build" projects in a formal contract negotiation with a payor, these efforts may prove unsustainable.

What is needed in its place is an articulated strategy that gradually builds the elements of an integrated delivery system that consumers anticipate. These phased innovations should address discrete problems and should have immediate impact on patient care. For example, improvement in standardization of care management is an absolute key to quality improvement and accountability in a system. Expansion of primary care services, including patient-centered medical homes (PCMH), is another baseline strategy. Integration of clinical services and best practices should then be jointly developed with PCMH and key specialty leaders in targeted therapeutic areas.

From this foundation, staff could dedicate itself to care management and case coordination, with particular attention to care transitions and individuals with highest utilization. Both centralized (telephone or virtual) and field-based, care management are vital. Information systems must support care management through clear care team roles, development of a single care plan and IT support of workflow. In addition, higher levels of analytic capabilities are also necessary to succeed under financial, risk-bearing arrangements.

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To be clear, these clinical improvements are essential linchpins to improved consumer experiences. But sustainable success over the long haul will ultimately hinge on safety net health systems negotiating profitable, risk-based financial contracts with payors. Retrospective value payment and shared savings are a good starting place. However, prospective payment streams are essential, starting with risk-adjusted care coordination fees for the sickest patients and then moving into broader risk payments, such as capitation, as capabilities and confidence build.

Consumers want a high-quality, high-touch, seamless experience whenever and wherever they touch the healthcare system. Safety net systems face many competing demands and tight margins. They must be focused and deliberate to achieve these consumer expectations and remain in service to their communities.

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