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building the foundation for value-based care

A primary care practice in Houston offers a lesson for all healthcare providers undertaking the transition to value-based care.

The tipping point. The point of no return. A critical juncture.

Call it what you will, but for value-based payment, the time is now. Providers that believe they are unaffected by the industry's move to value-based care may want to reconsider their position. For those that want to stay ahead of the curve, position themselves for success in the future, and deliver a better clinical model to their patients, it's not too late. But change is coming quickly. By 2018, 50 percent of all Medicare payment will be tied to value-based alternative payment models, recognizing not only the volume of care delivered but also the clinical outcomes that care generates. Commercial carriers all have followed suit. Billions of dollars of compensation are flowing through different value-based payment contracts to different types of providers for improved results.

Hospitals and health systems, in particular, that have successfully embarked on value-based contracting—for example, through an accountable care organization, bundled payment contracts, or another initiative aimed at population health management—understand very well the pivotal importance of primary care in such efforts. Thus, although the discussion here focuses on the experiences of a large primary care physician practice, the lessons recounted will resonate with any hospital or health system that either employs or affiliates with a large group of primary care physicians.

The fundamental point bears repeating: A primary-care-driven, patient-centric model is the core of a successful value-based model.

No group of physicians is more suited to improve patients' clinical results across the continuum of the American healthcare system. According to

AT A GLANCE

- Primary care serves as the foundation for all providers' efforts to deliver value under value-based contracts.
- With primary care as the engine, value-based care requires a clinical focus on identifying patients at high risk for disease progression for early intervention, expanding patient education services, coordinating care across sites and specialties, and eliminating redundant and non-evidence-based treatments.
- Key areas of focus include readmissions and care transitions, chronic condition management, emergency department utilization, and medication adherence.

one recent analysis, primary care accounts for approximately 6 percent of the total healthcare dollar, but by most estimates, primary care physicians' influence approximately 75 percent of the total healthcare spend.[a] Primary care delivered in a coordinated way, augmented with accurate data and the teams of support professionals, can significantly impact clinical quality and cost. With the right primary care models, patients benefit from increased access to care, reduced admissions to the hospital, improved health, and a supportive and meaningful relationship with their primary care physicians.

Moreover, finance leaders of hospitals and health systems should be well-acquainted with the types of strategies outlined here that are essential for achieving financial success under value-based contracts. A health system's CEO and senior finance leader should play active roles in ensuring the processes and culture are in place to support the level of care coordination required for the effective delivery of value-based care.

Understanding Value

Delivering primary care within a value-based model involves much more than changing contracts and compensation. It requires a proactive clinical focus, in which patients at high risk for disease progression are identified for early intervention, patient education services are expanded, care is coordinated across sites and specialties, and redundant, non-evidence-based treatments are eliminated—all with three key objectives: making patients healthier, providing high-quality care, and reducing the total cost of care. Success will be determined not by seeing more patients but by caring for patients at highest risk and maintaining strong relationships with healthy patients to keep them healthy—a vision that physicians have been pursuing for years.

Changing physicians' model of care delivery takes time and planning. Although it's not rocket science, it involves much more than simply relabeling the same old system and expecting different results. It's more than adding a care management nurse or staying open on a Saturday morning or obtaining claims data. Delivering value-based care requires digging deeply into the needs of patients, identifying gaps in care, understanding the type of support and access patients need to be able to participate in managing their health, and then truly meeting patients' needs. When value is delivered, patients benefit from improved care, physicians can focus on clinical and not administrative work, and both physicians and patients can benefit from a reduced total cost of care.

Retooling the Core

Success in a value-based contract depends on three elements that are at the core of any healthcare operation: people, processes, and technology.

People. Value-based care requires teamwork from clinicians both inside and outside the primary care practice. Prevention, early intervention, wellness, and post-discharge care are provided by integrated care teams that include physicians, care coordinators, disease educators, pharmacists, and behavioral health specialists. In a high-performing model, hospitals, skilled nursing facilities, and other ancillary providers all understand and support the primary care clinical model and the goals of improved quality and efficiency, and network partners understand the need to use data to drive continuous improvement and commit to timely communication and data sharing. Transition of care management is most effective with timely notification of admissions and discharges. Hospitals and specialists unwilling to help primary care physicians manage their patients to the best clinical result will be

a. VillageMD internal managed care contract analysis, 2015.

ADDITIONAL INSIGHTS

Listen to author Clive Fields' comments regarding the implications for hospitals and health systems of the need for a primary-care-focused strategy to achieve success under value-based care.

Look for HFMA's *Voices in Healthcare Finance* podcast, episode 8, at soundcloud.com/hfma.

Essential Elements of Value-Based Contracts

Nearly every commercial and Medicare Advantage payer has value-based contracts in the marketplace. These contracts fall into various types and some offer more risk than others. The boilerplate contracts generally are not advantageous to providers ready to commit their organizations to a value-based delivery model; the contract provisions and payment levels of these standard contracts typically do not align to the level of depth and expertise required to drive successful performance under the contract. To ensure that upside is consistent with the healthcare organization's investment in new care delivery models and the overall value generated, contracts should incorporate the following:

- A fair method for patient attribution and ongoing attribution management provisions, including the provider's ability to revise and influence the attributed patient population
- Clear rules for how often and when the provider will receive ANSI 835 Claims files and ANSI 834 Benefit Enrollment files
- Access to prior authorization, utilization management, member services, and care management data
- Payment for cognitive ancillary services such as annual wellness visits, chronic condition management, and transitional care management
- The ability to influence disease-specific carve-outs
- Audit rights related to accurate claims payment, influencing subrogation
- A percentage-of-premium payment structure that incorporates total premiums received
- The ability to provide separate reinsurance
- The ability to negotiate incurred-but-not-reported (IBNR) run-out or reserve reconciliation agreements (i.e., an extended "tail" on run-out, which is particularly important for a Medicare Advantage population)

These are complex topics and provider organizations should identify their internal subject matter experts and include them in all contracting discussions. If expertise does not reside in-house, providers should consider finding an outside partner who can support contract negotiations and management with respect to these areas.

excluded from primary care physicians' networks. And hospitals that own primary care practices will obtain marginal benefits from such ownership if they do not provide such essential support to the physicians.

Processes. Processes that promote greater coordination of care should be explicitly defined and implemented. Delivering comprehensive, coordinated care requires the use of guidelines and best practices aimed at reducing variation and promoting clinical excellence. Clinical standardization applies not only to physicians, but also to any point of contact within the care delivery system for patients, whether it be a provider, a facility, a support staff member, something less tangible. The way phones are answered, patients are scheduled, and nurses are used to help complete quality metrics each presents an opportunity for reducing variability and improving outcomes.

Technology. Technology can be a lifejacket or an anchor. Technology that integrates data from diverse sources, assists in risk stratification, or improves patient outreach and education is critical for success in a value-based contract. The key for primary care physicians is to use

technology that helps drive their clinical models rather than attempt to change their clinical models to fit the capabilities of the technology. Technology should help primary care physicians execute their strategies, not define them. Technology that puts data in the hands of physicians at the point of patient care will create the greatest impact. For example, all clinical notes from the physician, care manager, diabetic educator, and pharmacist are loaded into the electronic health record (EHR) and accessible to all members of the care team at the point of care. Outside claims data also are integrated into the EHR so it can generate alerts to gaps in care, which can be addressed while the patient is present in the office.

Executing the Value: Village Family Practice

Understanding the components of a value-based contract and the work necessary for success is step one; next comes the hard work. Many physician practices struggle to implement the programs, processes, and outreach that truly provide benefits for patients. Identifying high-risk patients does not reduce risk. Hiring a care management nurse does not reduce readmissions. Providing a patient a handout on a chronic disease is not the end of patient education.

Village Family Practice (VFP), a multisite, 50-provider primary care practice in Houston, offers a case example of types of actions that are required for success under value-based contracts. VFP began providing services under value-based payment programs 20 years ago. In the intervening time, the practice underwent a continuous evolution, with constant changes based on lessons learned about how best to meet the needs of its patients and the nature of its contracts.

As a result of these efforts, VFP has developed programs, processes, and practices that address access to care, patient engagement, and chronic disease management. These programs drive improved outcomes and total cost of care savings. The work has resulted in:

> Medicare admission and readmission rates 25 percent lower than the community average
> Total cost of care for Medicare patients 20 to 35 percent lower than the community average
> Total cost of care for commercial patients 10 to 15 percent lower than the community average

Following are real-life examples of how VFP has effectively used a value-based approach to deliver high-quality care at a reduced total cost of care.

Readmissions and transitions of care. The 30-day all-cause readmission rate for Medicare patients is consistently around 15 percent, a significant failure and cost driver of the nation's healthcare system.

To tackle this problem, VFP initially focused on best practices: coordinating with hospital discharge planners, scheduling office visits shortly after discharge, and creating multidisciplinary care plans. This was a good first step, but it did not achieve VFP's goal.

The creation of data feeds from VFP's local hospitals allowed the organization to identify a greater number of its admitted patients shortly after admission. VFP developed a more structured hospitalist program and focused on improved discharge planning beginning at the time of admission.

For elective surgery, VFP works with its surgeons to provide pre-operative clearance and use that clearance to begin to set the patient's expectations of the post-operative time period. If a patient has a total joint replacement scheduled, VFP works with the surgeon to ensure home health services and all needed therapies are delivered in a timely way and within its network of providers.

VFP uses a LACE score to identify patients at highest risk of readmission.[b] LACE is a nationally recognized risk stratification tool, introduced in 2010, that takes into account the patient's length of stay for an admission, acuity of illness, comorbidities, and number of emergency department (ED) visits in the prior year. A patient's risk for readmission is scored on a scale of 1 to 20, with patients having a score of 10 or higher being considered high risk.

VFP also takes into account patients' social circumstances as key determinants in supplementing the LACE score: Does the patient live alone? Does he or she have access to a pharmacy? Can the patient afford prescribed medications?

Patients with a LACE score greater than 10 receive a home visit from a nurse practitioner (NP) within 48 hours of discharge. The NP focuses on medication reconciliation, removing barriers to follow up, and providing education on what a patient can expect for his or her disease or procedure. Many times, a skilled NP can provide a range of services typically delivered by multiple different providers, thereby reducing cost and improving the coordination of care.

Further, the NP performs all of these tasks in coordination with the patient's primary care physician, leveraging long and trusted relationships to deliver the best possible care.

In the first quarter of 2016, this approach resulted in 30-day readmission rates of less than 8 percent in VFP's Medicare Advantage population. The high cost of Medicare readmissions in the Houston market, averaging about $18,000, underscores the importance of reducing readmissions as a key element in VFP's strategy for success in value-based contracting.

Chronic condition management: diabetes. Diabetes is a major health concern all across the country. According to the most recent statistics on disease prevalence, roughly 11 percent of the adults in Texas suffer from diabetes.[c]

VFP uses a coordinated approach that ensures that each diabetic patient receives consistent care to manage his or her disease and limit its complications. The organization has specific rooming guidelines for diabetic patients used by all nurses and medical assistants across all practice sites. These guidelines define how every diabetic patient should be prepped for the physician exam.

For example, before the physician enters the room, a nurse or medical assistant has drawn blood; ordered labs for HgBA1C, lipids, and blood chemistry; ordered a urine microalbumin test; made necessary referrals for retinopathy and peripheral vascular exams; and removed the patient's shoes. VFP's rooming guidelines also include specific health questions to ask diabetics in advance of the physician exam.

VFP's chronic care managers work with diabetic patients to develop care plans and clinical goals, customized around the needs of each patient's lifestyle, cultural practice, level of family support, and food likes and dislikes. When patients perceive these care plans as being their personal plans, they are more likely to comply with the plan requirements.

As a diabetes Center of Excellence, VFP provides on-site peripheral vascular and retinopathy screening. VFP also is certified by the American

b. See van Walraven, C., Dhalla, I.A., Bell, C., Etchells,, E. Stiel, I.G., Zarnke, K., Austin, P.C., and Forster, A.J., "Derivation and Validation of an Index to Predict Early Death or Unplanned Readmission After Discharge From Hospital to the Community," *CMAJ*, April 6, 2010.

c. See "2013 Diabetes Fact Sheet—Texas," Texas Department of State Health Services, Updated December 2015.

Diabetes Association (ADA) as diabetes education site. VFP applied to the ADA for certification to ensure that its program met the highest standards for education quality and clinical quality—and was certified in February 2014.

As a result of VFP's approach, in the practice's Medicare fee-for-service (FFS) diabetic population, the cost per patient is 16 percent lower than the Medicare FFS benchmark. Rates of admission considered potentially preventable given proper primary care (the ambulatory care sensitive admissions rate) is 36 percent lower than the Medicare FFS benchmark.

Simply put, consistent clinical care, early detection of complications, and a focus on patient education and engagement are all critical to managing chronic diseases such as diabetes that are likely to be present in a large number of a healthcare organization's patients.

ED utilization. Overuse of the ED is symptom of a broken primary care system. According to the National Institutes of Health, $38 billion is associated with unnecessary ED use annually, with about 56 percent of all ED visits being avoidable. Recognizing the drivers of ED use, VFP redesigned it practice to help reduce the number of nonemergent visits to the ED.

To address the issue of access, VFP instituted night and weekend hours to meet its patients' needs. Because a number of its patients were going to the ED between 8 a.m. and 5 p.m., however, VFP also was compelled to review its clinic schedules to allow for walk-in and urgent care appointments.

In essence, the message VFP wants to convey to patients is, "We are here when you need us; your calls are not a 'bother.'" Most important, VFP also wants that message to assure patients of its commitment to continuously learning new ways to improve its level of service in the future.

This message is particularly appealing to families with children. All too often, pediatric visits to the ED result in no intervention other than reassurance. VFP's goal is to enable its patients to speak to clinicians day or night to receive advice and reassurance without the cost and inconvenience of an ED visit.

VFP's data indicate that complaints of pain are among of the top reasons for an ED visit. Within that category, migraines are a common complaint. In the past, patients would run out of their medication, experience a migraine, and have no course of action other than an ED visit. With practices that include guaranteed same-day appointments and emergency one-day refills on migraine medication, VFP's patients can avoid an ED visit, with its associated cost and inconvenience.

Data analytics and patient education should drive physicians' strategies to reduce avoidable ED utilization. Knowing who, why, and when people go to the ED helps to identify the specific interventions patients need. Physicians can take advantage of proactive opportunities through patient education and access, and reactive opportunities with post-ED follow-up and education about alternative sites of service. No single clinical strategy exists in a vacuum; physicians should be encouraged to use every opportunity to educate their patients on how and when to use the healthcare system to help drive the best possible cost and quality outcomes.

As a result of this strategy combining patient messages and physician engagement, VFP's commercial ED visits per thousand are 11 percent lower than the market average. This reduction was driven by a 33 percent lower rate of avoidable

ED visits relative to the market. The result drives bottom line cost: VFP's risk-adjusted ED costs in this population are 8 percent lower than the market.

Medication adherence. Medication errors are a significant contributor to avoidable cost and morbidity. VFP focuses not only on ensuring patients do not neglect taking their prescribed medications, but also on making sure patients take those medications in a way that is consistent with the physician's directions. Patients neglect to take their medications for four primary reasons:

> They cannot afford to pay for the medications.
> They don't understand why the medications are important.
> They experience an undesirable side effect.
> They run out of medications without an easy way to fill them.

VFP has implemented programs to address all four issues.

Point-of-care pharmacies at VFP's clinics improve access to medications and foster communication among patients, primary care physicians and pharmacists. Having access to VFP's EHR lets the practice's pharmacists contribute in real time to a patient's medication regimes, offering suggestions around cost and clinical opportunities. When patients understand that the pharmacist is integrated into the practice, they are more open to accepting the pharmacist's comments reinforcing a physician's suggestions and warnings.

VFP has a home delivery service for medications. Pharmacy aides make the deliveries and can, with pharmacist oversight, perform medication reconciliation at the time of delivery. Nothing is more valuable than seeing first-hand how patients manage their medications in their own homes—beyond what they say at the physician's office.

These approaches have earned VFP's pharmacy 5 star ratings from the practice's payer partners. Meanwhile, the generic utilization rate among VFP's patients for primary care prescriptions is 92 percent, which contributes significantly to the practice's success in achieving the Triple Aim of medicine.

Leading the Way

Fixing a healthcare system that is fragmented and broken in so many areas is a staggering task to contemplate. Primary care physicians are in a prime position to take on that task and effect meaningful change by promoting a systems of coordinated care, informed with data and supported by care teams. Physicians can use data to identify the opportunities, their clinical training to create clinical interventions, and their teams and partners to help carry out their vision. With the right strategies, interventions, and support, success in the world of value-based health care is well within reach. ■

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