MAKING THE LEAP

Value-based care best practices for hospitals and physicians

A WHITE PAPER FROM THE HEALTHCARE EXPERTS AT Primaris
Healthcare Business Solutions

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In January of 2015, the U.S. Department of Health & Human Services (HHS) announced aggressive goals to push Medicare – and really the entire healthcare system – further toward value-based payments. HHS's goals of moving from volume to value include tying 50 percent of fee-for-service Medicare payments to value by the end of 2018.

This announcement, along with a subsequent one from the Health Care Transformation Task Force that proclaimed its alliance of prominent payers and providers had committed to putting 75 percent of its business into value-based arrangements by 2020, confirmed once and for all that the transition to the value-based model is really happening.

Even before these declarations, pioneering physicians, hospitals and other healthcare providers recognized value would eventually replace volume, and they began transitioning their organizations to value-based care. The HHS announcement drove some new providers to join the value movement, but there are still a lot of holdouts that are sticking with traditional care processes and waiting to see how the early adopters fare. After all, fee-for-service is still profitable and value is unknown.

For healthcare providers, there are both opportunities and challenges tied to value-based care. Those who can deliver on cost, quality and patient outcome measures are able to earn financial incentives and avoid penalties.

Of course, figuring out how to achieve these things is tough. But there are some known success strategies that are emerging around areas like care coordination, population health management and risk-sharing.

This resource shares some best practices for hospitals and physicians that can help organizations achieve value-based care goals.

Best practices for hospitals

Hospitals must quickly seize opportunities to extend service offerings and make structural changes that reduce readmissions, improve patient satisfaction, and increase care quality.

Work to treat patients quickly and completely. All hospitals aim to help patients get well so they have no need to stay in the hospital. Unnecessarily long stays are not beneficial to patients, and they contribute to high care costs. Hospitals can put evidence-based guidelines into practice and use them to consistently deliver efficient and effective treatment.

Evidence-based care involves applying the best available evidence to clinical decision-making. Evidence-based guidelines give providers direction that helps eliminate guesswork. With fewer judgement calls to be made and a map to guide care procedures, evidence-based guidelines can help hospitals treat patients more quickly and with better outcomes.

Getting patients treated and discharged quickly should not be confused with sending them home before they are ready. Patients need to completely meet discharge requirements before they are released, and those requirements must not be compromised. Otherwise patients could face all sorts of negative health consequences, avoidable hospital readmissions, and needless care costs.

Begin planning early for discharge. The more prepared and informed patients are when they leave the hospital, the less likely they are to be readmitted. That is why it is important to frequently communicate with patients about discharge instructions, and not bombard them with an overwhelming amount of critical information just as they are preparing to leave.

Have the requirements for release in place and begin planning for discharge as early as possible. Almost immediately, determine the level of health patients need to achieve before they will be released to leave. As they progress to that point, seize opportunities to educate them about their health, assess their understanding of their conditions, and help them plan appropriately for their ongoing care needs.

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medications they have been prescribed, what medical equipment they'll need and how to use it, who they should contact if they have questions, and so on.

Utilize your time with patients appropriately to answer questions and provide information and instruction throughout their stay. That way, when patients are eventually released they will leave with a clear understanding of what they need to do to make sure they don't end up back in the hospital.

Support patients with post-discharge services. Hospitals have assumed more responsibility for patient health outcomes. They are now accountable for patients even after they've left the confines of a hospital's walls, and therefore need to manage patient care cycles both inside and outside of the hospital.

For hospitals to minimize risks, they need to make sure patients have the necessary resources available when they return home or move to a post-acute care facility. Rather than leaving these arrangements up to patients, or passing them on to the next care provider, hospitals must take actions to coordinate post-acute care services.

A patient that is returning home may need transportation to and from appointments, they may need to have meals provided, or prescriptions delivered. Hospital care coordinators can help make arrangements for patients or put them in touch with organizations that can provide needed services.

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These efforts on the part of hospitals can improve patient satisfaction, reduce readmissions, lessen costs, and deliver better health outcomes – all of which are things hospitals need to be conscious of under value-based care models.

Nurture relationships with post-acute care providers. Hospitals need to have strong working relationships with post-acute care facilities so that care can be coordinated. In some cases that means hospitals need to mend relationships that previously have not been productive.

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Hospitals should form teams and reach out to their communities to ask for input on what they can do differently inside the hospital to make patient experiences better outside of the hospital. This means reaching out to pharmacies, skilled nursing facilities and others within the care community. Once lines of communication have been established, hospitals can give the outside providers input on adjustments they can make as well.

Another option is to bring in a third-party to act as a mediator and give both sides direction on how to work together effectively. This can be a good way to get the ball rolling and eventually improve care coordination and outcomes.

Explore partnership opportunities. Not only do hospitals need to work more closely with other care providers, but they may also want to explore affiliation and partnership opportunities.

Some value-based payment options, like many ACOs, require that hospitals meet minimum patient population guidelines. Smaller hospitals do not always have the volume to meet these minimum patient requirements on their own. However, they can explore opportunities to join with other groups to create larger networks that will be eligible for different reimbursement models.

A handful of hospitals can come together, form an ACO and increase their ability to contract with commercial insurers. Plus, by participating in an ACO, hospitals show they are committed to meeting specific quality outcomes that mean high-quality care for patients.

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Best practices for physicians

Under value-based care, physicians are measured by how well they manage entire patient populations. Therefore, physicians must become more proactive providers and adept at managing data.

Learn to work with data. As the industry transitions to value-based healthcare, physicians need to embrace data in order to manage entire populations of patients. Within patient records there is a wealth of data that can be used to understand how specific conditions are being controlled within a practice. Physicians need to harvest the information and put it to use. They need the capability to run a report and see how many of the diabetic patients within their practice have their blood pressure under control, or quickly pull a list of patients that have elevated blood glucose levels. With information like this, physicians can reach out to at-risk patients and efficiently manage chronic conditions in groups of people. By attacking chronic conditions in groups, rather than looking at each individual case, physicians can work much more efficiently.

Patient satisfaction is a measure that value-based care uses to evaluate the performance of physicians. ACOs, for example, include patient satisfaction as part of the overall quality standards physicians must meet in order to earn savings. Understanding and improving patient satisfaction also requires a degree of data management.

Physicians need to survey patients and collect information to learn how patients feel about the services they receive. Finding out that patients think wait times in the office are too long, or that appointment availability is lacking, allows physicians to make adjustments that can lead to better patient satisfaction. Making these types of changes requires having patient-reported data available in the first place.

Fully utilize Electronic Health Records (EHR) technology. According to The Office of the National Coordinator for Health Information Technology's report to Congress last October, 48 percent of physicians had at least a basic EHR system in place in 2013. That is a good start. But considering that intelligent use of data is really only possible when an electronic medical records system is being used, even more physicians need to participate in meaningful use of EHRs.

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Financial incentives are available for demonstrating meaningful use. Plus, physicians and staff can work smarter with EHRs in place. For these reasons, physicians that have not already done so need to adopt an EHR system and maximize the use of that system.

A big topic surrounding EHRs now is interoperability. Healthcare providers know that they need to communicate with others in their community and coordinate patient care. Right now there are some barriers that make complete data sharing difficult. As the industry works to develop better technology, physicians need to keep their eyes on the interoperability movement and look for ways to better their current EHR use.

Focus on patient populations. As mentioned above, total population management is something every physician needs to strive for in the age of value-based payments. It simply is not feasible to routinely evaluate every single patient's health individually, monitor their test results, provide outreach and education, and offer other preventive services while trying to improve efficiency and cut care costs.

However, physicians can monitor groups of patients, and therefore recognize when individuals have fallen into high-risk categories that require more attention. At that point, specific actions can be taken to target the high-risk patients and deliver appropriate care. Even patients that are grouped into low-risk categories can be targeted with appropriate outreach designed to encourage participation in preventive care.

Physicians should identify some of the sub-populations within their practice that they want to begin monitoring. They can look at data from the overall population and determine where the greatest needs are within their patient set. Maybe 650 of a physician's 1800 patients are struggling with obesity. If so, this is a group to examine closely. By using lab results and running a report, that physician's office can identify how many of those obese patients are diabetic and struggling to keep blood glucose levels under control. Then the physician's team can give more targeted attention to these individuals.

Be proactive instead of reactive. Because physicians accept greater accountability for patient

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outcomes under value-based payment models, they need to become much more proactive about managing the health of their patients. This can be one of the biggest adjustments for physicians. It is no longer enough to treat patients just during office visits when they show up with an acute condition. Physicians need to add between-visit care to the services they offer. This way they can more effectively control health outcomes and meet care quality requirements.

Reaching out to patients to let them know they are due for a mammogram, following-up with patients that have started a new blood pressure medication, or contacting a specialist to discuss care plan details for a mutual patient are just a few examples of the proactive care efforts physicians are expected to assume. The point is, physicians (and their teams) must work to preserve the health of patients on an ongoing basis, not only during office visits.

Develop internal team quality experts or find a quality improvement partner. A final point for physicians to realize is that they may want to find an advisor or vendor that they can partner with for help analyzing performance and improving quality, clinical, and financial outcomes. Quality improvement can be done internally. But if physicians find they don't have the know-how or the bandwidth to make major changes, looking for outside help is a good option.

Physicians know that their livelihood is going to be heavily impacted by how well they meet quality measures. But many don't have experience in data mining and management, patient outreach, and other areas that affect quality. Often physicians can benefit from finding a partner to help them get up to speed on the quality improvement processes and procedures they need to be successful.

The shift from volume to value is inevitable. These best practices represent many of the success metrics that are used to measure hospitals and physicians in the world of value-based healthcare. Finding ways to incorporate these points into care routines will give hospitals and physicians opportunities to provide better care and capitalize on financial incentives.

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Primaris is a healthcare consulting firm that works with hospitals, physicians and nursing homes to drive better health outcomes, improved patient experiences and reduced costs. We take healthcare data and translate it into actionable quality improvement processes that create the foundation for highly reliable healthcare organizations.

Primaris has more than 30 years of experience advising healthcare organizations on how to improve quality, patient safety and clinical outcomes. Contact us to learn more.

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200 N. Keene St., Suite 101
Columbia, Mo. 65201
Phone: 1.800.735.6776
www.primaris.org

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