Population Health NEWS

New Words, New Mindset, New Healthcare Success

by Jamo Rubin

For many healthcare and hospital leaders, discharge signals the end of patient care. But for most patients, it's just the beginning of their journey. To provide truly comprehensive and empathic care, healthcare leaders should accompany their patients throughout their entire journey back to recovery and health.

Innovative healthcare organizations are doing just that. They're changing the way we think about and deliver care. They are strengthening connections between patients and providers. And they are building connections where none previously existed, including between providers and patients' families and providers and community resources. As a result, they're getting closer to achieving the Triple Aim: better outcomes, lower cost and improved experience. It's time to find ways to create connections throughout each patient's journey to give them and their family the support needed to live happier, healthier lives.

Rethinking the Vocabulary

Healthcare is often thought of in strictly business and clinical terms instead of from a patient's perspective. For example, the term "discharge" relates to billing and isn't a word patients or their families would likely use.

While billing transactions, including diagnosis-related groups (DRGs) or Current Procedural Terminology (CPTs), might be complete from the business standpoint, patient and families are just beginning the journey back to health.

The word "discharge" carries baggage that can prevent providers from determining what successful treatment really looks like in fee-for-value contracts. The concepts associated with discharge simply focus on getting patients out of the hospital. They don't provoke thoughts or concerns about external barriers, such as patients' financial situations, which can hinder their ability to achieve a full recovery. Terms like "discharge" and codes like DRGs and CPTs don't really exist in a value-based agreement as they do in a pay-for-service one.

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This is why "transition" may be a better description of what happens when people leave a hospital or clinic. It is a term with which patients and their families can better relate. Also, as fee-for-service payments and incentives are increasingly replaced by a fee-for-value environment, healthcare leaders and providers will become accountable for such transitions from one phase of care and treatment to another. Helping patients and their families with these transitions can and do generate a Triple Aim win for everyone. "Care" can either simply describe specific activities that only take place in the clinical realm, or it can encompass all activities required to return patients to health. This includes addressing personal, social, financial and community issues.

Fee-for-Service vs. Fee-for-Value

In a fee-for-service environment, incentives simply drive more activity. The impact, or outcome of that activity, bears little or no relationship to reimbursement. But in a fee-for-value environment, more activity does not necessarily result in greater reimbursement. Instead, increased activity over an extended period of time, whether aimed at solving clinical challenges or social/financial/community issues, only makes sense when it benefits both the patient and provider. To put it another way, fee-for-value allows more efficiency and maximizes gains by reducing steps physicians and patients must take to get the best possible end result.

For example, in a fee-for-service environment, a patient in the process of getting a knee replacement might see multiple providers, pay varying costs and yet never experience the quality of care that will ensure swift recovery. As outcomes are often not measured in a fee-for-service environment, full recovery of a patient is often not tracked and supported as it should be.[1] As a result, quality measures suffer.

On the other hand, in a fee-for-value environment, the same knee replacement process would look very different. The Comprehensive Care for Joint Replacement Model (CJR),[2] a program starting in April 1, 2016, that supports better and more efficient care for Medicare beneficiaries undergoing the most common inpatient surgeries, would create a sense of "forced accountability," in which healthcare leaders would work as a "team of teams."

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In this new model of care, the patient would receive coordinated, consistent care, in which high quality is at the forefront, and outcomes will determine incentives. In fact, hospitals would receive bonus payments for delivering high-quality care, contributing to the Centers for Medicare and Medicaid Services' (CMS) goal of making 50% of all Medicare fee-for-value payments via alternative payment models by 2018.

Connecting Providers, Community Resources

Triple Aim goals can be achieved by not just strengthening existing connections between providers and patients, but also by building new connections where none previously existed, such as those between providers and community resources.

Based in Little Rock, Ark., CHI St. Vincent, a system of four hospitals that manages more than 50,000 lives—primarily employees and dependents via risk-based contracts—has a joint replacement program that serves as a good example. Approximately 48% of CHI St. Vincent's joint replacement patients come from outside its primary service area.

CHI St. Vincent took many of the steps that most hospitals take to achieve the Triple Aim, including standardizing care practices, physician orders and physician leadership/administrative support hierarchies and developing a comprehensive preoperative, patient education program. But it also began incorporating a patient support, management system into the clinical pathway of its program.

This support system takes a highly focused approach to workforce utilization, uses data and analytics to drive treatment success, streamlines the processes surrounding follow-up calls and strives to help providers understand and solve issues, such as lack of transportation and social connections and other barriers to care. Immediately upon implementing the system, fewer patients required post-acute care, and readmissions began dropping.

Another hospital received CMS recognition for reducing 30-day readmission rates among heart failure patients below 10% by connecting patients to needed resources to promote recovery and ensuring regular follow-up calls within 48 hours of discharge and at 30-day intervals.

These examples show that finding and solving a person's social/financial/community barriers can be done quickly, generating outsized value compared to the cost of solving them. They also demonstrate process improvement that service lines and hospitals often experience as they follow new workflows.

Extending Care Beyond Discharge

Healthcare organizations could begin extending care beyond discharge by:

1. Challenging the current mindset and ways of doing things.
2. Starting to help "people," not "patients." This is the ultimate goal of fee-for-value reimbursement. Empathic thinking is an amenable road to success in a fee-for-value business model.
3. Collaborating with community organizations to provide the time and money needed to solve social, financial and community barriers that would otherwise potentially result in higher costs, worse outcomes and negative experiences.
4. Viewing individuals receiving care as real customers.
5. Building workflows and systems that connect providers to resources beyond the walls of a clinic, hospital and electronic medical record (EMR). Collaboration and communication could serve as primary drivers of successful fee-for-value contracts.
6. Reconceiving provider roles to be successful in a contract that redefines how they get paid.

Legacy hospital and physician leaders will have to decide if they are the right ones to lead this transformation, or if they need to add new members to a leadership team that has the vision, and authority, to move an organization in the right direction. Change is hard and not to be underestimated. But by shifting mindset and building new connections, better outcomes, lower costs of care and a better healthcare experience for patients, families and providers could result.

[1] Porter ME, Lee TH. "The Strategy That Will Fix Health Care." *Harvard Business Review*. October 2013.
[2] "Comprehensive Care for Joint Replacement Model." CMS.gov.

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