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Cross-Continuum Partnerships for Population Health and Value-Based Care

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One of the many things that need to change in the American healthcare system is the fragmentation of delivery that exists across the care continuum. Imagine if the airline industry operated like the healthcare industry, and each traveler had to maneuver through separate contracts with the airline, pilots' union, baggage handling company, and airport. Yet, that's the current state of affairs with healthcare where someone with a chronic condition like diabetes is likely, over the course of their disease, to need separate arrangements with their primary care physician, hospital, hospitalist, ED physician, endocrinologist, home health agency, skilled nursing facility, and perhaps even a few examples of providers along the care continuum coordinating care around a single patient and working together according to best-practice, evidence-based guidelines.

Public hospitals and health systems and their boards have a special responsibility to ensure that their organizations provide care that is highly coordinated, cost-effective, and that results in high-quality outcomes. This responsibility emanates from the fact that public hospitals often care for the most vulnerable populations—i.e., those most likely to get lost or possibly harmed by a system that is disjointed and not reliably delivering high value (quality per unit of cost) to its constituents.

Key Board Takeaways

Public hospitals and health systems have a special responsibility to provide care to the vulnerable populations they serve that meets the Triple Aim (i.e., high-quality care, improvements in population health, and lower costs across the system). To accomplish this lofty goal, public facilities should:

- Consider clinically integrating with their providers and designing coordinated care that can successfully operate under bundled payment models.
- Focus on true population health initiatives that attempt to impact some of the socioeconomic disadvantages that their populations face (e.g., high rates of poverty, illiteracy, substance abuse, and barriers to access).

Finding Solutions to Fragmented Care

The good news is that solutions are emerging to the problem of disjointed care. These advancements are emanating from a variety of sources including payers, providers, and even patients themselves. The following are examples of innovative models designed to deliver well-coordinated, patient-centered care:

- **Bundled payments.** It has been known for some time that bundling reimbursements for services around procedures (e.g., total joint replacement or heart surgery) or episodes of care for medical conditions (e.g., pneumonia or heart failure) can improve quality outcomes and lower costs. One way that bundled payments drive these improvements is through better coordination of care among the diverse providers across the continuum and agreements among the providers to follow best-practice guidelines when appropriate. The Centers for Medicare and Medicaid Services (CMS) is leading the charge in this area and has recently introduced bundled payment models for 32

episodes of care with 29 in the inpatient and three in the ambulatory arena.

- **Clinical integration.** Over the last decade or so providers have come together to organize care delivery processes that more reliably deliver high value. These clinically integrated networks (CINs) can then also jointly contract, without violating anti-trust restrictions, for value-based payments (e.g., the bundled reimbursements outlined above). The most successful of these CINs have recognized that effective and efficient care delivery must include coordination of care across the continuum. The CIN provides the perfect venue to design such care processes in that it legally allows providers from disparate employment models to work cooperatively to drive value to the consumer and to be rewarded for doing so.
- **Care process design.** Healthcare providers now realize that if effective and efficient care is the goal, then all participants across the continuum need to be on the same page. The good news here is that clinical research and developments in technology now allow for providers at different points in the care process to agree on evidence-based guidelines and to communicate a single patient's response to care in near real-time. Also occurring is a significant move toward having patients assume more responsibility for their healthcare, especially with chronic disease management of conditions such as diabetes, hypertension, or smoking-related lung disease, where the patient is best positioned to manage their own care on a day-by-day or even minute-by-minute basis. Unfortunately, there is still a lot of room for improvement in this realm as the lack of interoperability between IT systems and the gaps in knowledge regarding clinical care stand as obstacles to the design and implementation of real best-practice care. Nevertheless, the industry is slowly moving forward, and improvements are occurring rather rapidly.

Potential Barriers to Value-Based Payment Models

There are some unique barriers that public hospitals and health systems may face regarding value-based payment models. For example:

- They usually serve large populations of uninsured patients. Thus, the concept of value-based payments is somewhat irrelevant to these organizations that provide a lot of safety-net services. However, the mission of most public hospitals is to serve a largely indigent population, which makes it even more important that they provide high-value care (i.e., care that is both high quality and cost-efficient).
- They often do not have the resources to transition from a largely volume-based model to a value-based model (i.e., it is more difficult for them to pay for things like care management staff, IT infrastructure, and providers who are experts in population health management).
- They are more at risk to the will of the politicians at the federal and local level to support their operations.

Public hospitals and health systems that choose to provide more value-based care should consider focusing on true population health initiatives (e.g., preventive services, chronic disease management, and community outreach efforts) that attempt to impact some of the socioeconomic disadvantages that their populations face, such as high rates of poverty, illiteracy, substance abuse, and barriers to access.

Providing an Optimal Patient Experience across the Continuum

The public hospital or health system that is interested in providing their patients with an ideal patient experience across each location of the care continuum should strongly consider:

1. Joining or organizing a clinically integrated network of providers where care guidelines can be set, and coordination of care can be managed.
2. Contracting through the CIN for bundled payments, which have been proven to drive improvements in cross-continuum coordination of care.
3. Designing or redesigning care processes across the continuum to include:
    - The pre-acute care area: primary care practices, retail medicine and urgent care centers, emergency departments, ancillary service providers, care management and disease management providers, telemedicine services, etc.

- The acute care area: hospitals, surgery centers, endoscopy centers, etc.
- The post-acute care area: post-acute rehabilitation (inpatient and outpatient), skilled nursing facilities, nursing homes, home health, hospice, etc.

The successful public hospital will consider implementing all the above and effectively transition to a more high-value care delivery model that will bring greater value to those they serve.

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