Collaborations for Value-Based Care: Necessary and Advantageous for All

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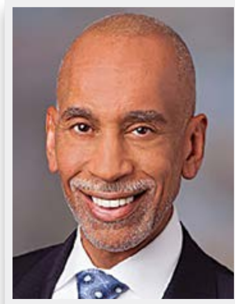
Key Board Takeaways

Hospitals and health systems can expand their traditional focus on quality healthcare to incorporate enhancing overall population health by:

- Collaborating with non-healthcare entities to provide complementary assets like healthy nutrition and means to increase physical activity.
- Leveraging the positive health outcomes that are achieved from these partnerships to succeed in the growing environment of value-based care that rewards these good outcomes.
- Ensuring senior leaders and the board lead the formation of a successful collaboration of stakeholders by showing that each derives returns from their asset investment.

Focus on Health, Not Just Healthcare Delivery



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Hospitals and health systems contribute importantly to their communities through delivering high-quality *healthcare*, but they also have the opportunity to enhance overall *health* of the communities they serve, including historically underserved areas with comparatively poor health outcomes. The current focus on the *process* of healthcare delivery nevertheless has not improved overall health outcomes[1] and populations, particularly historically underserved ones, seek improved health outcomes, not just equitable and high-quality healthcare.[2] Improving the populations' health obligates that hospitals and health systems collaborate with partners outside the industry that can invest non-healthcare needed assets to yield the improved health outcome returns. Healthcare boards and senior leaders have the opportunity to initiate and even lead this creative approach.

The Need

Reimbursement systems are evolving from rewarding processes and episodes of healthcare delivery to rewarding good health outcomes. In this environment of so-called value-based care[3] (VBC), hospitals and health systems suffer financially for poor health outcomes, even those outcomes related to contributing factors for which they have no direct control. Contributing factors include social determinants of health (SDOHs), which disproportionately cause poor health outcomes for underserved populations.[4] Traditional healthcare models do not address or routinely consider SDOHs in clinical care.[5]

The Challenge

A VBC reimbursement environment challenges hospitals and health systems to address the many factors outside of healthcare that contribute to good health outcomes, recognizing that delivered healthcare makes a proportionately smaller contribution to good health outcomes than SDOHs.[6] In addition, members of underserved communities have generally had limited access to healthcare so a continued focus on healthcare delivery alone will fail to reach these individuals who, when they do need healthcare, often access it emergently and at increased cost.[7] Together, this incentivizes healthcare organizations to develop strategies to address SDOHs to function in a VBC environment. Achieving VBC therefore obligates hospitals and health systems to reach beyond the boundaries of clinical care.[8] Healthcare organizations will need to reach out to the communities they serve and develop functional relationships,[9] particularly with historically underserved communities.[10]

The Opportunity

Evolution of the reimbursement environment to VBC, with its focus on good health outcomes, provides a common vision around which healthcare organizations and communities can align. This alignment will lead to efforts to achieve good health outcomes among all populations, including eliminating the effects of SDOHs on historically underserved populations. This approach also harmonizes the historic dissonant focus on healthcare delivery verses health outcomes between hospitals and health systems and communities, respectively.

Because achieving good health outcomes requires investment of non-healthcare assets, hospitals and health systems must collaborate with entities such as food producers/distributors and fitness centers that can invest these assets in ways that will achieve these returns. Examples of such assets include adequate nutrition and resources to facilitate increased physical activity. Holders of these needed additional assets historically have not integrated them functionally with traditional healthcare delivery.

1 Joseph Dieleman, et al., "Factors Associated with Increases in U.S. Health Care Spending, 1996–2013," *JAMA,* November 7, 2017.
2 P. Braveman, et al., *What Is Health Equity? And What Difference Does a Definition Make?*, Robert Wood Johnson Foundation, April 2017.
3 Sylvia M. Burwell, "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care," *The New England Journal of Medicine,* March 5, 2015.
4 Susanne B. Nicholas, Kamyar Kalantar-Zadeh, and Keith C. Norris, "Socioeconomic Disparities in Chronic Kidney Disease," *Advances in Chronic Kidney Disease*, January 2015.
5 American Hospital Association Committee on Research, *Next Generation on Community Health*, 2016.
6 Bridget C. Booske, et al., *Different Perspectives for Assigning Weights to Determinants of Health,* University of Wisconsin, Population Health Institute, February 2010.
7 American Hospital Association Committee on Research, 2016.
8 Donald E. Wesson, et al., "Innovative Population Health Model Associated with Reduced Emergency Department Use and Inpatient Hospitalizations," *Health Affairs*, April 2018.
9 Elizabeth McGlynn and Mark McClellan, "Strategies for Assessing Delivery System Innovations," *Health Affairs*, March 2017.
10 Donald E. Wesson and Heather Kitzman-Ulrich, "How Academic Health Systems Can Achieve Population Health in Vulnerable Populations through Value-Based Care: The Critical Importance of Establishing Trusted Agency," *Academic Medicine*, June 2018.

Consequently, healthcare organizations must develop the new skill of integrating these additional assets into their routine operations. Healthcare leaders will most likely have to initiate the conversations that will lead to building these functional collaborations.

The Results

Our experience at the Baylor Scott & White Health and Wellness Center in Dallas, Texas, supports that mutual asset investment yields returns for each contributing stakeholder, making this an attractive approach. Healthcare leaders often have the standing and gravitas within the larger community to facilitate the necessary collaborations. For example, executive leadership of Baylor Scott & White Health (BSWH) proactively established a collaborative partnership with the City of Dallas Park and Recreation Department and with local churches to develop VBC strategies for five contiguous low-income Dallas zip codes. The collaboration consisted of a level-three family medicine clinic placed in a local parks and recreation center and "farm stands" located in select recreation centers and churches that distributed fresh fruits and vegetables at very low cost to this official "food desert" community. Making the clinic contiguous with resources to support increased physical activity and provide healthy nutrition allowed integration of evidence-based lifestyle changes with traditional outpatient healthcare delivery. The collaboration increased use of the recreation center with the accompanying financial and social benefit to the City of Dallas, improved health outcomes of church members and their leaders, and significantly reduced utilization of the BSWH's emergency department and inpatient resources with the attendant reduction in healthcare expenses for care of this largely uninsured population.[11] These mutually beneficial outcomes incentivize each collaborator to invest in the partnership. Establishing these effective working relationships required first establishing mutual trust, beginning with system leaders reaching out to these collaborating entities and demonstrating early "wins" in the process.[12]

A Proposed Approach

Hospitals and health systems must evolve with the rapidly changing healthcare environment and, as discussed, will very likely do so in collaboration with leadership of entities outside of healthcare. Going forward, boards and senior leaders should consider doing the following:

- Begin internal conversations around how best to reconfigure operations that would allow for integration with non-health system assets in support of achieving good health outcomes.
- Develop the skills to identify needed partners for achieving good health outcomes and to work collaboratively with them on an ongoing basis.
- Establish an ongoing process of monitoring the effectiveness of the collaboration.

Concluding Remarks

It's critical that hospitals and health systems work towards achieving good population health outcomes, but they cannot do so alone; they must collaborate with other entities that can invest the needed additional assets for success. The partnership will sustain when collaborators see mutual returns for their mutual investments. Healthcare leaders have the opportunity to reach out and proactively help establish this needed collaboration and ensure that these partnerships are continuing to make a difference in the communities they serve.

The Governance Institute thanks Donald E. Wesson, M.D., M.B.A., President of the Baylor Scott & White Health and Wellness Center, and Professor of Medicine at Texas A&M Health Sciences Center College of Medicine, for contributing this article. He can be reached at donald.wesson@bswhealth.org.

11 Wesson, et al., April 2018.
12 Wesson and Kitzman-Ulrich, June 2018.