Implementing Value-Based Health Care Delivery in Nebraska

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Health care affects every person, and the stories people tell about their care speak volumes about our health care delivery system. Some stories highlight the best of what health care can be – they are heartwarming descriptions of health restored, concerned and loving caregivers, cures that appear miraculous. Unfortunately, other stories illuminate the gaps in our system. Too many of these stories are of failed health, complications made more complex by siloed, disjointed care, errors that should not have occurred, or missed opportunities to heal. Fixing health care – moving it to a place where more people enjoy better health – requires a focus on creating value and a commitment to a fundamental redefinition of care delivery.

Value in health care is the improvement in health for the costs incurred. Moving to a value orientation has been more difficult because too few organizations measure the health outcomes of their care, and too few can accurately measure the actual costs of the care they deliver to individual patients. The commitment of the Nebraska Medical Association and its leaders, together with a state-wide effort to improve health and care, puts the state on the cusp of tremendous change.

Across the state, clinicians agree that the goal of health care must be better health. Making better health outcomes the singular goal of health care delivery transformation will address many of the problems that plague the system. People seek care when their health is threatened. Producing better health outcomes reduces the demand for health services. Examples abound demonstrating that better health is less expensive than poor health, and effective care reduces costs of complications and disability.

Historically, health sector competition was about dividing value. Competition focused on shifting costs – imposing higher co-pays on patients, excluding services from coverage, moving patients among care venues, and arm-wrestling over reimbursement rates. These efforts raise the overall costs of care by introducing unnecessary paperwork, bureaucracy, inefficiencies, transaction costs, delays, and complications. These activities frustrate physicians and other caregivers who prefer to put their time and energy into efforts that create value for patients and families.

Greater value means more health, success and efficiency, and it involves fewer problems, treatments, and hassles. Any size organization, from a single-physician practice to an integrated delivery network, can redesign care

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delivery to achieve value improvement for patients.

The first step in redefining care delivery is to organize care delivery for excellence in what many patients need, and customize occasionally. Organizing around groups of patients with similar medical circumstances flips the current presumptions, freeing clinicians to focus time and resources on the needs of those who require the same types of tests or treatment, or those who need to make similar kinds of lifestyle changes. Bringing similar groups of patients together also creates natural networks of patients who can coach, support and assist each other as they work to achieve better health.

When there is similarity among the patients, it is easier to assemble and deploy a multi-disciplinary care team to treat them. For example, a primary care practice that groups most of its patients with Type 2 diabetes one day per week can more easily offer group medical appointments, partner with a pharmacist, retain diabetes educators, exercise

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coaches or nutritionists. For multi-location practices, this kind of patient and caregiver grouping is even easier. As teams work together to deliver care, they become more effective and more efficient in delivering care.

Teams organized around the needs of medically similar patients can more easily deliver comprehensive solutions for those patients' needs. Particularly in the context of lifestyle-driven chronic conditions, convenient solutions are essential to enable patients to succeed with their health. Many clinicians have found that the presence of a consistent, closely-coordinated team of caregivers allows them more time to focus on their area of expertise and to gain a deeper understanding of the circumstances and challenges that those patients confront.

When care is structured around groups of similar patients over their continuum of needs, it is dramatically easier to measure the health outcomes of care. Teams can more easily see the outcomes that matter most to enabling patients to achieve better health. Teams that consistently work together also find it easier to measure the outcomes of their care and to learn from those measures. Outcome measurement is a potent tool for improvement, and conversely, the failure to measure outcomes impedes caregivers' ability to improve.

Having outcome measures also makes it far easier to demonstrate superior value creation. When teams can show that their patients recover more fully, their diseases progress more slowly, they miss less work or suffer less disability, it is far easier to structure payments that align with that value creation. New kinds of partnerships, with employers, health plans, and the government, are far easier to envision and to create when providers measure the results of the care they deliver.

Change is always challenging and changing the structure of care delivery amidst ongoing care for patients is particularly daunting. The Nebraska Medical Association's commitment to value is impressive and inspiring. Its desire to bring organizations together and to support caregivers through meaningful transformation is promising, and experiments across the state are beginning to demonstrate better care, improving health and lowering costs. □

"There's a Hole in the Bucket..." *(continued)*

unsuccessful or, even worse, actually add risk to the patients' health. Physician leadership is critical for this to succeed.

- Physicians need to utilize more cost-effective and fewer low-value options such as those outlined in the American College of Physicians' High Value Care Initiative.
- Education of providers regarding the cost of services we provide – beginning at the student level and continuing throughout their careers. Patients, corporations, insurers, and the government will demand cost-efficiencies and we will need to know how to manage these with the best interest of the patients in mind.
- Physicians and payers will need to collaborate for this to be successful. Sharing data should be a two way street, results of quality metrics and claims based data if analyzed correctly will have more impact together than separately.
- Development of Accountable Care Organizations (ACO) can facilitate the process of incorporating data into the workflow to increase the value of the services—improving both outcomes and patient satisfaction while containing costs. Utilization of electronic records at the clinic level and inclusion of patient satisfaction as a key measure in value are important differentiators from the prior HMO model.

Improving health care for our patients will be a team effort, but physician input is essential for the transformation to occur. Our role as stewards to protect and provide care to our patients is ingrained as to who we are and why we chose this profession. Our patients need us now more than ever. Let's stop the leak and preserve health care for future generations.

1) Kuehn, B. Guidelines, Online Training Aim to Teach Physicians to Weigh Costs of Care, Become Better Stewards of Medical Resources. JAMA. June 04, 2014. doi:10.1001/jama.2014.5756 □