

PREPARING FOR VALUE-BASED CARE: A GUIDE FOR HEALTH CENTERS



**NATIONAL
NURSE-LED CARE
CONSORTIUM**
a PHMC affiliate

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ABOUT THE NATIONAL NURSE-LED CARE CONSORTIUM

The National Nurse-Led Care Consortium (NNCC) is a national leader supporting and advocating on behalf of nurse leaders. NNCC is a nonprofit member-supported organization, and provide a wide range of services to educate and support both nurses and other primary health care professionals. NNCC advances the quality of health care through policy, consultation, and programs to reduce health disparities and meet people’s primary care and wellness needs. NNCC is an affiliate of Public Health Management Corporation (PHMC).





INTRODUCTION

As the healthcare landscape continues to rapidly evolve and value based care becomes the method for reimbursement, primary health care is re-envisioning modalities by which care is delivered. Primary care providers are tasked with responding to a payer environment that emphasizes quality outcomes and reduced costs over patient volume. A team-based model of care is an integral component to competing and succeeding in a value-based payment landscape.

Health centers have long been at the forefront of healthcare innovation, partnering with community agencies, patients, and families to provide care that accounts for social determinants of health and the holistic needs of the people they serve. Health center providers are well-positioned to advance value-based care by improving upon policies already in place, such as co-located dental, vision, and behavioral health services, case management, and outcome tracking through the Uniform Data System (UDS) report. Most critically, community health centers are comprised of interdisciplinary teams tasked

with the delivery of coordinated care to low-income, high-risk patients and communities. Roughly 92% of all health center patients are at or below 200% of the federal poverty limit, and health centers serve special populations (such as residents of public housing) that are statistically at a higher risk for a myriad of chronic and acute conditions.¹ To best serve this population and meet the demands of a value-based payment environment, health center staff must form and optimize care teams designed to reduce costs and improve patient outcomes.

WHAT IS VALUE-BASED CARE?

The inception of the Patient Protection and Affordable Care Act of 2010 formalized what many providers (and payers) have long suggested: that care should be delivered holistically, centered around quality, and funded based on patient outcomes. Value-based models emphasize the need for providers to administer care based on reimbursable quality metrics and benchmarks. Unlike the prospective payment system (PPS) rate, value-based payments are designed to compensate for services that address the chronic needs of health center patients. As health centers offer more services through non-traditional settings and modalities, value-based payment models are poised to sustain patient-centered care and promote efficient, effective approaches to achieving optimal patient health.

WHY VALUE-BASED CARE?

Community health centers serve over twenty-seven million patients nationwide. As of the 2017 UDS report, approximately 50% of patients served at health centers are insured by Medicaid. Consequently, health center administrators and providers must be prepared to adapt to changing guidelines from the Centers for Medicare and Medicaid (CMS), including recent value-based Medicare trends. Private insurers are also moving away from volume-based payment models, developing contracts and agreements with providers that underscore quality goals for patients.

Early pilots of value-based care programs show promise. CMS' Physician Group Practice Demonstration realized \$137.8 million in savings and resulted in positive patient outcomes across an array of disease states, including diabetes and hypertension. A pay-for-performance model implemented across health center sites in Chicago demonstrated improved provider compliance with HbA1c testing recommendations.

Initial successes in quality-based payment and resulting legislative changes have ushered in a transformative environment for many providers, especially those with large Medicare and Medicaid populations. CMS, for example, is required to funnel reimbursement through one of two mechanisms as part of a quality payment program: merit-based incentive programs (MIPs) and advanced alternative payment models (APMs). This change necessitates advanced planning among health center providers to prepare for payments that reward value, not volume. More than half of all health center patients are insured via Medicaid (49.64%) or Medicare (9.40%), positioning health center staff to be particularly affected by changes in CMS reimbursement policies.

VALUE-BASED DESIGNS

There are a variety of value-based payment mechanisms in place throughout the U.S., including those spearheaded by CMS. Other value-based designs include pay for performance, accountable care organizations, and bundled payments. While by no means exhaustive, this list of mechanisms includes trends in payment that are already in effect for some health centers, and may be on the horizon for others.

Pay for Performance (Value-Based Purchasing)

The premise of a pay-for-performance value-based care design involves financial penalties and bonuses for providers based upon their commitment to and provision of high-quality care. These payment adjustments are allocated dependent upon pre-determined, program-specific measures of quality, often including patients' clinical outcomes and experiences. Pay-for-performance programs show unique promise in that incentives can be designed to emphasize the explicit needs of patients and payers in certain healthcare systems.

Accountable care organizations

Accountable care organizations (ACO's) are comprised of teams of providers who coordinate high-quality healthcare services for Medicare beneficiaries, while concurrently creating care settings that limit unnecessary costs for the insurance program. Patients are at the center of their own care, while clinicians and healthcare organizations share information that might contribute to any decisions to be made regarding the patient's health. ACO's encourage a focus on preventative care because there is more substantial financial incentive in avoiding illness than in treating illness.

Bundled payments

Bundled payment models allow Medicare to provide a single, set-rate reimbursement to several providers across specialties during one episode of care for a patient. Bundled payments encourage coordination of care between clinicians to increase quality of care, while also discouraging needless care expenditures to reduce Medicare costs.

WHAT DOES THIS MEAN FOR YOUR HEALTH CENTER?

What to expect

Value Based Programs

| | 2008 | 2010 | 2012 | 2014 | 2015 | 2018 | 2019 |
|---------------------|-------|------|--------------------------|------|-------|---------|--------------|
| LEGISLATION PASSED | MIPPA | ACA | | PAMA | MACRA | | |
| PROGRAM IMPLEMENTED | | | ESRD-QIP HVBP HRRP | HAC | VM | SNF-VBP | APMs MIPS |

LEGISLATION

ACA: Affordable Care Act

MACRA: The Medicare Access & CHIP Reauthorization Act Of 2015

MIPPA: Medicare Improvements For Patients And Providers Act

PAMA: Protecting Access To Medicare Act

PROGRAM

APMs: Alternative Payment Models

ESRD-QIP: End-Stage Renal Disease Quality Incentive Program

HACRP: Hospital-Acquired Condition Reduction Program

HRRP: Hospital Readmissions Reduction Program

HIVBP: Hospital Value-Based Purchasing Program

MIPS: Merit-Based Incentive Payment System

VM: Value Modifier Or Physician Value-Based Modifier (PVBM)

SNFVP: Skilled Nursing Facility Value-Based Purchasing Program

Source: Centers for Medicare and Medicaid

Value-based care is here. The passage of the Affordable Care Act in 2010 and, subsequently, the Medicare Access and CHIP Reauthorization Act of 2015 legislated mandatory changes for CMS, including movement away from volume-based care toward value-based models. By 2019, all providers seeing Medicaid and/or Medicare patients will be reimbursed through APMs or MIPS. In the private market, insurance companies are increasingly negotiating contracts with providers that emphasize the importance of quality and patient outcomes. Many insurers are investing in ACOs, bundled payments, and pay-for-performance programs.

The Solution: Team-Based Care

WHY TEAM-BASED CARE?

Interdisciplinary care teams promote patient-centered care by instituting enhanced communication, role optimization, and the streamlined use of health-IT. Care teams are better able to track a patient's trajectory along the cascade of care through both acute and chronic care management.

Providing patients with team-based care has been shown to increase their satisfaction, engagement, self-care, and diabetes-specific outcomes (See Table 1). However, the benefits of care teams extend beyond the patients-- team members see improved satisfaction, productivity, accuracy, and turnover rates as well.

| | | | | |
|--|---------------------------------------|--|---|---|
| Patient Outcomes (% change) n=8 | <u>Satisfaction</u> 50% n=4 | <u>Engagement</u> 13% n=1 | <u>Adherence/ Self-Care</u> 25% n=2 | <u>Positive Diabetes Specific Clinical Outcomes</u> 25% n=2 |
| Care Team Outcomes (% change) n=7 | <u>Satisfaction</u> 43% n=3 | <u>Productivity/Efficiency</u> 57% n=4 | <u>Accuracy/Fewer Errors</u> 29% n=2 | <u>Fewer Turnovers</u> 29% n=2 |

Table 1. Outcomes associated with effective, multidisciplinary team medical care identified through a literature review of care team interventions (N=15). Patient outcomes include increases in satisfaction , engagement , adherence/self-care , and positive diabetes-specific clinical outcomes² (HbA1c and blood pressure improvement). Team outcomes include increases in satisfaction³ , productivity/efficiency⁴ , accuracy⁵ , and fewer turnovers⁶ .

In fact, care teams are central to many value-based payment models, including Patient-Centered Medical Home programs and Joint Commission standards. Care teams function optimally when team members practice at the top of their license, reduce waste and duplication, and utilize cost-saving communication to streamline patient care.

What Next?

What should your health center do to prepare for and capitalize on a value-based environment?

1. Assess your health center staff, capacity, and benchmarks

To adequately prepare for value-based care, health center staff can assess the current capacity to meet the changing demands of a rapidly-evolving healthcare environment. Benchmarking health center performance based on UDS data, Health Center Controlled Network (HCCN) measures, and patient satisfaction surveys provides staff with a set of priorities and goals that can shape healthcare delivery to de-emphasize volume and highlight successful patient outcomes and experiences. You can also use a pre-developed assessment tool, such as the Value-Based Health Care Strategic Planning Tool from the [National Rural Health Resource Center](#).

2. Accreditation

Joint Commission accreditation indicates that a health center has demonstrated commitment to patient safety, high-quality care, and data optimization. Many of the standards included in the Joint Commission’s ambulatory care accreditation process underscore competencies for value-based care, including care continuity, provider performance, and improved patient outcomes.

Care team formation and optimization

As discussed, interdisciplinary care teams promote patient-centered care by instituting enhanced communication, role optimization, and the streamlined use of health-IT. Care teams are better able to track a patient’s trajectory along the cascade of care through both acute and chronic care management. To learn more about care teams, read our publication, [Integrating Team-Based Care to Improve Clinical Outcomes: A Guide for Health Centers](#).

CONCLUSION

Health centers are primed to meet the demands of a value-based healthcare delivery landscape. As the providers of choice for over twenty-seven million patients, health centers play a critical role in the advancement of patient-centered, efficient care that both reduces cost and increases quality. By understanding the complex value-based care environment and taking steps to form and optimize care teams, health center staff can create a path to success that sustains the vital services they provide to communities throughout the country.

Endnotes

1. 2017 National Health Center Data. Health Resources and Services Administration Web site. <https://bphc.hrsa.gov/uds/datacenter.aspx>. Published 2018.
2. Abrams M, Nuznum R, Zezza M, Ryan J, Guterman S. The affordable care act's payment and delivery system reforms: a progress report at five years. The Commonwealth Fund Web site. <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-systemreforms-at-5-years>. Published 2015.
3. What are the value-based programs? Centers for Medicare and Medicaid Services Web site. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/value-based-programs/valuebased-programs.html>. Published 2017.
4. Gruessner V. Private payers follow cms lead, adopt value-based care payment. Health Payer Intelligence Web site. <https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adoptvalue-based-care-payment>. Published 2016.
5. Kautter J, Pope G, Leung M, et al. Evaluation of the Medicare Physician Group Practice Demonstration. Research Triangle Park, NC: RTI International. Published 2012.
6. Lorincz I, Lawson B, Long, J. Provider and patient directed financial incentives to improve care and outcomes for patients with diabetes. *Curr Diab Rep*. 2013;13(2):188-195.
7. A quick start guide to merit-based enhancement incentive payment system (MIPS). Centers for Medicare and Medicaid Services Web site. [ps://www.cms.gov/Medicare/Quality-Payment-Program/ResourceLibrary/Quick-Start-Guide-to-MIPS.pdf](https://www.cms.gov/Medicare/Quality-Payment-Program/ResourceLibrary/Quick-Start-Guide-to-MIPS.pdf). Published 2017.
8. Ryan AM, Damberg CL. What can the past of pay-for-performance tell us about the future of value-based purchasing in Medicare? *Healthcare*. 2013;1(1-2):42-49.
9. Berenson R, Upadhyay D, Delbanco S, Murray R. Payment methods and benefit designs: how they work and how they work together to improve care. The Urban Institute Web site. https://www.urban.org/sites/default/files/09_pay_for_performance.pdf. Published 2016.
10. Accountable care organizations (ACOs): general information. Centers for Medicare and Medicaid Services Web site. <https://innovation.cms.gov/initiatives/aco/>. Published 2018.
11. Bundled payments for care improvement (BPCI) initiative: general information. Centers for Medicare and Medicaid Services Web site. <https://innovation.cms.gov/initiatives/bundled-payments/>. Retrieved 2018.
12. Campbell SM, Hann M, Hacker J, et al. Identifying predictors of high quality care in English general practice: observational study. *Bmj*. 2001;323(7316):784.
13. Meterko M, Mohr DC, Young GJ. Teamwork culture and patient satisfaction in hospitals. *Medical care*. 2004;42(5):492-498.
14. Friedman DM, Berger DL. Improving team structure and communication: a key to hospital efficiency. *Archives of Surgery*. 2004;139(14):1194-1198.
15. Uhlig PN, Brown J, Nason AK, et al. System innovation: Concord hospital. *The Joint Commission journal on quality improvement*. 2002;28(12):666-672.
16. Koerner BL, Cohen JR, Armstrong DM. Collaborative practice and patient satisfaction: Impact and selected outcomes. *Evaluation & the health professions*. 1985;8(3):299-321.
17. O'Donnell MR, Daftary A, Frick M, et al. Re-inventing adherence: toward a patient-centered model of care for drug-resistant tuberculosis and HIV. *The International Journal of Tuberculosis and Lung Disease*. 2016;20(4):430-434.
18. Barba EL, de Miguel MR, Hernández-Mijares A, et al. Medication adherence and persistence in type 2 diabetes mellitus: perspectives of patients, physicians and pharmacists on the Spanish health care system. *Patient preference and adherence*. 2017;11:707.

Endnotes

19. Grace SM, Rich J, Chin W, et al. Fidelity of implementation to a care team redesign and improved outcomes of diabetes care. *International Journal for Quality in Health Care*. 2014;27(1):60-66.
20. Kyrkjebø JM, Brattebø G, Smith-Strøm H. Improving patient safety by using interprofessional simulation training in health professional education. *Journal of interprofessional care*, 2006;20(5):507-516.
21. Curley C, McEachern JE, Speroff T. A firm trial of interdisciplinary rounds on the inpatient medical wards: an intervention designed using continuous quality improvement. *Medical care*. 1998;36(8):AS4-AS12.
22. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *BMJ Quality & Safety*. 2004;13(suppl 1):i85-i90.
23. Siassakos D, Fox R, Crofts JF, et al. The management of a simulated emergency: better teamwork, better performance. *Resuscitation*. 2011;82(2):203-206.
24. Wright MC, Phillips-Bute BG, Petrusa ER, et al. Assessing teamwork in medical education and practice: relating behavioural teamwork ratings and clinical performance. *Medical teacher*. 2009; 31(1), 30-38.
25. Rivers RM, Swain D, Nixon WR. Using aviation safety measures to enhance patient outcomes. *AORN journal*. 2003;77(1):158.
26. Shortell SM, Zimmerman JE, Rousseau DM, et al. The performance of intensive care units: does good management make a difference?. *Medical care*. 1994:508-525.

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