Transforming Clinical Care: Why Optimization of Clinical Systems Can’t Wait

A White Paper

March 2016
Rapid Transition to Value

Can your organization withstand a 9% decrease in reimbursement? If yours is like most, the answer is a resounding “No.” But in fact that's what's at risk over the next few years from just one value-based program. In January 2015, the Department of Health and Human Services (HHS) announced new goals for value-based payment. By the end of 2018 they expect 50% of Medicare payments to be tied to alternative payment models, and 90% of Medicare fee-for-service payments to be tied to quality. The array of current value-based programs is dizzying with Meaningful Use, Value-Based Modifiers, PQRS, Bundled Payments, Hospital Acquired Conditions, Readmissions, Value-Based Purchasing and multiple varieties of ACOs. But in spite of the multitude of programs, growth in the amount of revenue tied to value has been slow. The announcement of these new goals signaled HHS's desire to rapidly escalate value-based payment, and they encouraged private payers to follow suit by meeting or exceeding HHS goals.

With the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015, HHS put legs to those goals. Physician fee schedule rates will increase by 0.5% each year from 2015-2019. Then in 2019, based on eligibility, physicians must choose to participate in one of two value-based tracks. The fee-for-service track, or Merit-Based Incentive Payment System (MIPS), replaces three existing performance programs: Physician Quality Reporting System (PQRS), EHR Meaningful Use (MU) and the Physician Value-Based Modifier (VBM). In MIPS compensation will be determined based on a composite performance score in four categories: quality, resource use, clinical practice improvement activities, and meaningful use of an EHR (see Figure 1). MIPS will introduce opportunities and risks based on value criteria, phasing in positive or negative payment adjustments that start at 4% in 2019 and gradually increase to 9% in 2022. Exceptional performers do have the opportunity to earn up to three times the positive payment adjustment (up to 27%), but because MIPS is intended to be budget neutral, there will be winners and losers, and it is expected that a considerable number of providers will be paid less.

Figure 1 – Components of Scoring Under the Merit-Based Incentive Payment System (MIPS)

As an alternative to participating in MIPS, providers who have a significant Medicare population can participate in an Alternative Payment Model (APM), such as an
Accountable Care Organization, Medicare Acute Care Episode or Quality Demonstration Program or other eligible model. In order to incentivize physicians to enter into APMs, MACRA offers an additional 5% annual bonus for services in 2019 to 2024, but like MIPS, APMs will also have quality reporting requirements, in which additional increases or decreases might apply.

On the inpatient side, CMS recently finalized a rule that will require hospitals in 67 markets to participate in a bundled payment program for hip and knee replacement surgeries starting in April 2016. Under the “Comprehensive Care for Joint Replacement” (or “CJR”) model, the hospital that performs the surgery on a Medicare patient will be held accountable for all spending associated with the ensuing “episode of care.” The “episode” will encompass the actual procedure, the hospital stay, and any related care provided to the patient within 90 days after discharge (including hospital care, post-acute care, and outpatient services). Affected hospitals will still be reimbursed on a fee-for-service basis, but at the end of each “performance period,” CMS will review the actual costs for a given episode of care. If that amount is under a target threshold established by CMS (and certain quality metrics are met), the hospital will be eligible for a bonus payment. If actual costs for the episode are higher than the target amount though, the hospital will be responsible for “repaying” the difference to Medicare.

Commercial programs are following suit. According to the December 2015 Leavitt Partners report “Projected Growth of Accountable Care Organizations,” commercial payers currently account for 54% of accountable care payment arrangements. As commercial payers realize the cost savings and see improved management of their populations through accountable care, they will increasingly favor these contracts. With widespread support of ACOs related to both commercial adoption and adoption related to the MACRA legislation, growth in ACO-covered lives is expected to increase from the current 23 million lives to 105 million lives in 2020.

Preparing For the New Paradigm

While these changes won’t occur overnight, there are considerable preparations to be made in order to succeed in the new paradigm. Thankfully, many of these preparations can begin to pay dividends right away.

Analytics Infrastructure

Ramping up technology, particularly related to analytics, for tracking quality and resource utilization metrics built into MIPS and APMs will be critical. As Medicare adjusts its payment model, organizations that aren’t ready to report on their value-based care efforts and achievements stand to lose significant revenue, both through penalties and through missed opportunities to receive value-based incentive payments.

The top challenge cited by ACOs is accessing data outside their organization, mentioned by almost 80% of ACOs recently surveyed. (“2015 ACO Survey Results,” eHealth Initiative, 9/8/15)
Consolidation

Merger and acquisition activity will likely continue. Smaller physician practices and health systems are unlikely to have the resources necessary to take full advantage of MIPS or participate in APMs. There will be continued consolidation into larger integrated delivery systems and physician employment to shape incentives appropriately to succeed in the new value-based payment environment. But consolidation brings its own set of challenges related to IT systems, workflows and culture, and health systems are likely to need help managing this.

EHR Efficiency

With providers having more and more to do during an office visit, including everything from preventive care, chronic disease management, capturing quality data, filling care gaps and adequately documenting for both clinical care and billing purposes, it is imperative to the success of healthcare organizations to make provider use of EHRs efficient. Most organizations have done little since EHR implementation to actually improve provider efficiency in the system, but going forward there will need to be considerable focus on specialty-specific build, minimizing clicks, making quality measure documentation streamlined and intuitive, and presenting providers with feedback in the form of performance dashboards. Highly usable EHRs encourage provider adoption, which not only decreases transcription costs, it improves capture of all the quality measures on which that payment will be based.

EHR Clinical Decision Support

Related to efficiency is the use of the EHR to drive behaviors. Clinical decision support is all about driving the right information to the right caregiver at the right time to help them make the right decisions. A strategy for knowledge management becomes critical for success in the new paradigm, as does presenting the knowledge in ways that drive correct behavior without interrupting workflows.

Reducing Variability

Perhaps nothing reduces cost more than reducing variability in care for both acute care episodes and chronic disease management. That means reducing length of stay for high impact conditions like Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Asthma by developing clinical pathways. Joint replacement and other bundled payment programs similarly benefit from clinical pathways and focusing on reducing testing duplication and over utilization can yield significant savings.

Revenue Improvement

Health systems shouldn’t let the focus on decreasing costs distract from also focusing on increased revenue opportunities. For the foreseeable future, hospitals will continue to

Total M&A activity in the healthcare delivery services sector grew 22% in 2015. Although hospital deals in 2015 were up only marginally from 2014, M&A involving physician practices increased 47%. (Irving Levin Associates press release, 1/26/16)
earn a significant portion of their revenue from procedures. In perioperative areas, maximizing block time utilization and improving first case start times can lead to considerable increases in throughput and revenue. The same is true in other procedural areas. Other areas to focus on for revenue improvement are maximizing coding through clinical documentation improvement, maximizing performance in incentive programs and reducing network leakage.

**Improving Quality/Safety**

Improving quality and patient safety is a key component of value, which is why there is already a strong emphasis on reducing hospital acquired conditions and length of stay. There are some key focus areas that will pay dividends both now and long into the future, like improving sepsis mortality, reducing catheter line days, improving management of Acute Coronary Syndrome and Stroke and reducing medication errors. On the ambulatory side, focus should be on improving chronic disease management for high-risk conditions like CAD, Diabetes, Hypertension (HTN), COPD, Asthma, and CHF.

**Care Coordination**

Certainly one of the key strategies for success in a value-based payment environment is IT-enabled care coordination. This includes predicting readmission risk and providing targeted transitional care to reduce readmissions for diseases like Heart Failure, COPD and Asthma. It also includes risk-stratified care management to improve chronic disease management for high-risk conditions like CAD, Diabetes, HTN, COPD, Asthma and CHF. IT tools are necessary to drive successful care coordination but they aren’t enough. There must also be focus on developing efficient, team-based care workflows to maximize fulfillment of care gaps.

**Improve Patient Experience**

Never before has there been such an emphasis on patient experience, but going forward keeping patients happy will be a key component of success. With the shift toward consumerism, patient loyalty is at an all-time low. That’s a problem both in a fee-for-service environment as well as a value-based environment. Providers need patients to be loyal to their network in order to control utilization and costs as well as maximize quality of care. To keep patients loyal, health systems need to focus on patient access and convenience. That means having availability for same day or even walk-in appointments in convenient locations, improving wait times in ambulatory offices and emergency departments, reducing turn-around time for test
results, streamlining referral processes, improving patient communication through patient portals and other modalities and providing telemedicine and mobile options.

**Improve Provider Experience**

Finally, it might be more important than ever for health systems to keep providers happy. Success in the new value-based paradigm is highly dependent on provider performance, and health systems need to attract and keep the best providers strongly aligned. It’s a new world for providers, and there will be a great deal of change management work necessary to traverse the transition to value-based payment. What today’s providers want is to be able to maximize their time spent in patient care and improvement in work-life balance. That means they need to minimize the time it takes to document their care, and EHRs need to support care activities. Key focus areas for provider engagement are improving usability and documentation and ordering efficiency, improving aggregate views of relevant patient information and clinical decision support optimization.

**Optimizing Clinical Systems Can’t Wait**

With rapid escalation of value-based payment looming on the horizon, health systems can’t wait to change. Preparations need to start now, and there needs to be ongoing commitment to clinical transformation for the long term. Organization that fall behind now will have a difficult time catching up and are likely to find themselves on the losing end of the value-based payment spectrum. Still, funding transformation activities is challenging and resourcing might be even more so. A pragmatic approach based on specific outcomes, focus areas and return on investment yields the least risk and most potential reward. Partnering with an experienced firm can streamline your efforts, supplement already stretched resources and maximize your chance of success.

More than 80% of physicians “describe themselves as either overextended or at full capacity” – but nonclinical paperwork takes up an estimated 20% of physicians’ time. *(Health Aff March 2016 35:388-389)*

Copyright © 2016 Impact Advisors, LLC.
All rights reserved.

These materials are provided to you by Impact Advisors as a professional courtesy for personal use only and may not be sold. Please appropriately credit/cite your source as “Impact Advisors, LLC.”

All copying for commercial use requires written prior permission secured from impact-advisors.com.
About Impact Advisors

Impact Advisors provides high-value strategy and implementation services to help healthcare clients drive clinical and operational performance excellence through the use of technology. We partner with industry-leading organizations to identify and implement improvements in quality, safety and value. Our Associates are experienced professionals with deep domain expertise and a commitment to delivering results.

Impact Advisors has helped many clients address their Clinical Optimization needs by drawing upon years of clinical, operational and IT experience. Our Clinical Optimization methodology provides an efficient and comprehensive approach to transforming clinical care.

Activities typically performed as part of our Clinical Optimization methodology include:

- Readiness Assessment
- Opportunity Assessment
- Optimization Roadmap
- Value Realization/ Prioritization Matrix Development
- Governance/Leadership for Optimization
- Data Governance
- Current and Future State Workflow Mapping
- Opportunity Prioritization
- KPI Development
- EHR Recommendations/ Build
- Change Management
- Communications Strategy
- Testing Strategy
- Training Strategy
- Implementation
- Performance Monitoring
- Sustainment Plan
- Clinical Documentation Improvement
- Clinical/ Population Health Analytics
- Population Health Workflow Optimization
- Physician Adoption
- Patient Engagement
- Clinical Informatics Program Development /Optimization

To learn more about Impact Advisors’ approach to clinical optimization contact:

tonya.edwards@impact-advisors.com or (864) 430-6227
mamie.stalvey@impact-advisors.com or (229) 412-0836

For more information visit: www.impact-advisors.com

Follow us on Facebook and LinkedIn