Part 3: The Value Mandate: What It Means for Your Organization

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This is the third in a four-part series examining emerging research and best practices to help health care providers get in front of the challenges and pressures of providing patient care in a post-reform era. Part I set the stage by examining the improve quality/reduce costs value mandate. Part 2 highlighted research studies that identify opportunities to lower costs without negatively effecting health outcomes by reducing and eliminating the 20+ percent of discretionary and medically unnecessary tests and procedures. Part 3 will address the challenges and benefits of coordinated and cost-effective care.

A pivotal goal under health care reform will be to deliver all health care services in a coordinated, efficient, and cost-effective manner. This new standard of care requires true clinical integration, timely information sharing, and shared accountability for both quality and cost management - all major challenges for providers, but with the potential for an enormous payoff.

Coordinated, Cost-Effective Care: The Untapped Potential of Chronic Disease Management

Chronic diseases such as heart disease, stroke, cancer and diabetes account for about 75 percent of national expenditures on health care according to data from the Centers for Disease Control and Prevention (CDC). A comprehensive study of the direct and indirect cost of seven of the most common chronic diseases, published by the Milken Institute, included an optimistic scenario (characterized by "reasonable improvements in health-related behavior and treatment") that would reduce treatment costs for these seven diseases by $217 billion in 2023, and total costs (including lost productivity) by $1.1 trillion.

The profound influence of one simple initiative, greater adherence to diabetes medications, was reported in a recent issue of *Health Affairs*. Using retrospective data from the information warehouse of a large pharmacy management firm, the authors of the study found that improved adherence to diabetes medications was associated with 13 percent lower odds of subsequent hospitalizations or emergency department visits, with potential cost savings of $4.7 billion on a national scale.

A new federal health analysis by the CDC demonstrates that the care of chronic care patients should not default into a discussion of the insured versus non-insured or under-insured. The study found that 36 million adults in the United States have high blood pressure that is not being controlled even though 32 million of them get regular medical care and 30 million of them have health insurance.

Without systems in place to provide care and education to patients who could benefit from intervention but fall through the cracks, even at highly respected institutions, patients suffer medical harm and the sizable costs of their care are added unnecessarily to national health care expenditures.

Managing the Care of Chronically Ill Patients

What complicates efforts to manage chronic diseases and conditions more effectively is that many of the critical interventions -- disease monitoring (e.g., checking blood sugar or blood pressure levels), assuring adherence to and/or adjusting medications, and providing advice on lifestyle changes -- need to occur on a regular basis in between doctor visits. Instead, far too often, critical interventions occur intermittently or not at all, between episodes of emergency room or inpatient hospital care.

Research and evidence from clinicians in the field now indicate that chronically ill patients are best cared for by primary care physician-led teams that maintain frequent contact with patients where they live (or in group settings) and provide the support and surveillance services needed to prevent or significantly reduce acute flare-ups. However, the theory into practice challenge emerges with this approach. The American College of Physicians has indicated that meeting the complex needs of patients with chronic illness or impairment is the single greatest challenge facing organized medical practices. Chronic disease patients need planned regular contact with caregivers that focus on function, prevention of complications, and supporting the patient's role in self care. Primary care practices, which provide access to care for patients with acute and varied problems, with a focus on short appointments, diagnosis and treatment of symptoms, brief patient education, and follow-up that is initiated by the patient, are not designed to meet the needs of chronically ill patients.

Acute care organizations have not excelled at providing this level of support to chronically ill patients either. However, large integrated delivery systems (IDSs) such as Kaiser Permanente or Geisinger Health System, which can easily share patient information and coordinate care among multiple physician and non-physician providers, adhere to internally developed practice guidelines, and have the financial incentive (by virtue of their insurance products) to provide needed care, and only needed care, in the most cost-effective manner are leading change in chronic care management in their markets.

In theory, accountable care organizations (ACOs), networks of providers accountable for both the quality and the cost of the care they provide to Medicare beneficiaries they are responsible for, will function as integrated delivery systems. In reality, while ACOs are likely to improve quality (as measured by adherence to care processes), the fact that Medicare patients will be allowed to see any Medicare provider, either inside or outside the ACO accountable for their care, will challenge ACOs to deliver care that resembles the coordinated, cost-effective care provided within Kaiser, Geisinger, or any other well-developed IDSs today.

Keys to Success

With private insurance companies advocating ACO-like models that focus on care delivery and emphasize health outcomes, health care organizations will increasingly be accountable for both the cost and cost-effectiveness of the care they provide to an enrolled population. The keys to success in this new environment are threefold:

1. A large, geographically distributed network of primary care physicians, supported by adequate numbers of advance practice clinicians, including nurse practitioners and physician assistants
2. A robust clinical information system that facilitates sharing timely, patient-specific clinical information among multiple providers, ranging from medical and surgical specialists to home health providers, with the primary care team at the hub
3. An organizational culture that values patient-centered, team-based care, with physician leadership that strongly advocates multidisciplinary care and actively supports an increased role for primary care providers as both caregivers and care coordinators

We will examine the role of physician leadership in the value mandate in Part 4 of our Survive and Thrive Under Health Care Reform series.

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