AMA | STEPSforward™

Preparing Your Practice for Value-Based Care

Make the shift to value-based care and benefit both your practice and your patients

AMA IN PARTNERSHIP WITH Move to Value

CME CREDITS: 0.5

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How will this module help me adopt a value-based care model?

1. Five STEPS to prepare your practice for value-based health care
2. Answers to common questions about becoming a value-focused organization
3. Case vignettes describing how physicians can create value-based practices

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. This model differs from the typical fee-for-service in that it focuses on the outcomes of patients' health and is reimbursed or rewarded accordingly. Unlike traditional fee-for-service care models that are focused on increasing volume, value-based approaches focus on improving patient outcomes. They are patient-centered and are often most effectively accomplished by a team-based approach to care.

Prepare your practice for value-based care
Release Date: March 2016
End Date: March 2019

Objectives
At the end of this activity, participants will be able to:
1. Identify their patient population that is the best opportunity for value-based care
2. Design their care model
3. Identify potential partners in their community
4. Define unnecessary costs in their practice
5. Evaluate their progress to determine the impact on their target population

Target Audience
This activity is designed to meet the educational needs of practicing physicians.

Statement of Need
By the end of 2016, Medicare will be tying 30 percent of its payments to alternative payment models; by the end of 2018, that number will be 50 percent. In addition, a major component of the Affordable Care Act is to change the way providers are paid: instead of paying based on how many patients a provider sees, it will be based more on patient outcomes (reducing readmissions, unnecessary tests, etc.). A module such as this will aid providers in learning how to implement value-based care in their practices.

Statement of Competency
This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Accreditation Statement
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement
The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Claiming Your CME Credit
To claim *AMA PRA Category 1 Credit*™, you must 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

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About the Professional Satisfaction, Practice Sustainability Group
The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy," and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement
The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types
This activity is available to learners through Internet and Print.

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Introduction

What is value-based care?

Unlike traditional fee-for-service care models that link payment to the number and type of individual services utilized, value-based care is intended to at least partially link payments to patients' health outcomes and/or quality of care. Over the last five years, the Centers for Medicare and Medicaid Services (CMS) has implemented several payment programs that cut Medicare physician payment rates in response to lack of compliance with CMS definitions, measures and processes; commercial payers have followed suit.

> "I have seen patients go from disengaged to self-motivated, from helpless to hopeful, from naive to empowered by education and knowledge. This clinic has not only saved lives but has changed lives as well. The positive impact has a ripple effect, where we are not only impacting their heart failure but their overall health."

Ursula Grant, Nurse Practitioner, Cornerstone Cardiology Heart Function Clinic, High Point, NC

Five STEPS to prepare for value-based care

1. Identify your patient population and opportunity
2. Design the care model
3. Partner for success
4. Drive appropriate utilization
5. Quantify impact and continuously improve

1 Identify your patient population and opportunity

Knowing your patients is the foundation of value-based care. Patient populations that have the highest risk of hospitalization or are high utilizers of the emergency department (ED) tend to drive high health care costs and most often receive fragmented care. These populations include poly-chronic patients—those with chronic and complex conditions with multiple co-morbidities, such as diabetes, heart failure, cancer, kidney failure and chronic obstructive pulmonary disease. Understanding which patients are driving your highest cost of care and are frequent utilizers of the ED will help you identify your target population and opportunities for improvement. Once you have this information, you can begin to develop your model.

Q&A

As a primary care provider, I see patients with many of the conditions listed. What techniques can I use to hone in on the right patient population(s)?

You can use private or commercial tools to identify the target patient population. Using population health analytics from your own Electronic Health Record (EHR), a **patient registry** or other population health technology can help you target critical diagnoses and determine which patients need immediate intervention. If you have the capital, you may also consider purchasing analytic software that can develop predictive risk stratification models or help you define priority based on volume. Regional health improvement collaboratives often maintain multipayer claims databases that can assist in this analysis. Capturing the top five to fifteen percent highest risk patients from your current population will help you identify those at risk for future high health care costs. For more information on developing population health management techniques in your practice, see the **panel management module**. Physicians may also want to consult with payers to identify patient population targets.

Are there other considerations I should make when evaluating opportunities to implement value-based care?

Yes. Patients in the practice whose conditions are not adequately controlled are more likely to cost your practice through no-shows, are less likely to adhere to their medications and may call in more frequently for medication refills than patients whose conditions are well managed. Downstream effects to consider beyond ED and hospitalization costs include home health costs, durable medical equipment (DME) costs, the need for referral to skilled nursing facilities and pharmaceutical costs.

Does my patient's insurance plan matter?

A patient's insurance plan does not and should not influence the quality of care patients receive. However, the reality is that the insurance plan does impact referral patterns and benefits that can be offered to the patient in order to keep his or her out-of-pocket expenses to a minimum. Additionally, insurance plans will have different quality metrics tied to value-based care.

The way the practice is paid also impacts its focus (where services are traditionally paid based on utilization of individual services). Transitioning to new models is one way to financially support a new emphasis on value.

2 Design the care model

Develop care models that are evidence-based and easy to follow. You can consider the following elements in the development of your value-based care model:

- Identify the target patient population(s).
- Identify which payers will be involved.
- Estimate how the type and volume of services will change.
- Identify the benefits expected for patients and payers.
- Design the workflows required to provide the desired care to the selected patient population.
- Discuss details including:
    - Staff who will support the new model
    - Roles and responsibilities of each physician and their support team
    - Frequency of patient contact (via phone call, email or portal messaging)
    - Frequency of patient visits to the practice
- Identify measurable success metrics for each population and determine your baseline in order to quantify your impact in the future. Your metrics should be easy to capture in the EHR or population health registry to prevent having to manually extract them.
- Identify transition costs (as a note, revenue needs to be addressed as well as risk-stratification).

Depending upon the caseload and capabilities of your team, current team members could potentially fill the staffing needs of the new value-based care model with proper education and redistribution of responsibilities. Utilizing current staff can be cost effective during the initial transition period, but additional staff may be needed as the model continues to be adopted by the practice, particularly since these new value-based models rely on effective care coordination and require a greater amount of data capture and analytics. Roles of the team members who care for patients in the model could include:

Patient outreach coordinators

Non-clinical team members who can utilize patient registries and analytic tools to reach out to patients who need:

- Care for a targeted medical condition
- Transitional support to ensure appropriate follow-up after receiving a new diagnosis or care in the ED or hospital
- Preventive maintenance tests or exam

Nurse educators/navigators

Registered nurses with specialized training in motivational interviewing and case management can positively impact the health of patients by extending the traditional reach of providers and their clinical care teams. This team member can intervene with the most vulnerable populations between office visits to educate and assist them in better managing their chronic health conditions. Registered nurses can schedule appointments and cover patient education, as well as provide the hands-on support and partnership that patients need to improve their health.

Care coordinators

Medical assistants (MAs) with training in population health management, clinical documentation and quality improvement who can work closely with the nurse navigators to provide follow-up communication and care coordination for at-risk poly-chronic patients. MAs can routinely check in with patients to support adoption of healthy behavior changes and work independently or with patient outreach coordinators to identify and close care gaps through patient engagement.

Super Mas

Certified MAs (CMAs) who can perform medical record reviews for patients scheduled for upcoming clinic visits, coordinate daily huddles, obtain all pertinent vitals and labs, complete medication reconciliation and set the visit agenda with the patient. In this augmented MA role, the CMA has the opportunity to start identifying gaps in care in preparation for the physician visit and then document the visit while in the room with the physician. After the physician finishes the encounter, the CMA makes sure the patient understands their plan of care and answers any questions. This type of workflow allows the provider to focus more on the patient and ensure that all the patient's needs are met during a single office visit, thereby increasing provider productivity and quality, while reducing clerical burden. The CMA is able to answer patient questions and coordinate patient care after the visit, providing continuity and consistency for patients.

Referral coordinators

Personnel responsible for both scheduling referrals and obtaining any precertification required by the patient's insurance company. Referral coordinators also follow up with the patient to confirm that the appointment is kept. Referral results are obtained by the referral coordinator and scanned into the patient's medical record for the physician to review. If any follow-up care is needed, the coordinator can connect with the patient and schedule the proper appointment.

Transition of care nurses

Nurses who provide support and care coordination services to patients undergoing a transition between different levels or venues of care. This function requires meticulous attention to the details of a patient's care, including, but not limited to, medication reconciliation, discharge instructions, resource availability for outpatient or community-based care and provider follow-up within a defined time frame. In your practice, these nurses could make sure that patients who are seen in the hospital or ED receive the follow-up care they need in the practice by scheduling appointments.

Extensivists and hospitalists

The extensivist team works alongside the hospitalists, ensuring that patients receive the appropriate follow-up care and care coordination after they are discharged. Hospitalists and extensivists work hand-in-hand with care transition teams to ensure that proper follow-up care is received and understood by the patient and
care team.

Some practices also use nurse practitioners, care managers and others to assist with care transitions and patient care management.

Q&A

What is the best staffing model for implementing a value-based care model?

The best staffing model is one tailored to your patients' needs and your practice's goals. The practice should anticipate how many patients will benefit and build the appropriate team to effectively achieve the chosen metrics.

One group practice organization found that a single health navigator could effectively address the needs of 250 patients at a given time, even for populations with many patients with poly-chronic and complex conditions. This ratio may or may not be appropriate based on the health status of the patients within your population. Continuous reevaluation of the staffing model is necessary to ensure that:

1. the needs of your patients are being met
2. unnecessary costs are being prevented
3. a sustainable future is ensured. The Case Management Society of America offers a matrix that can be helpful in determining the appropriate caseload for your practice.

Can we combine several functions into one position?

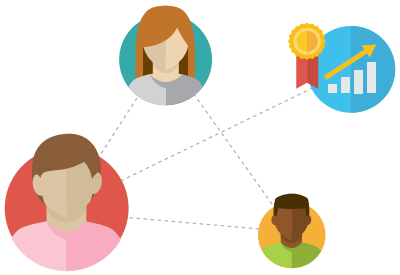
Yes. In many organizations one staff person functions in multiple roles, for example, a receptionist may also be the patient outreach coordinator, helping to close care gaps using the panel management tool. Some organizations have found that a high functioning nurse may do the work of a navigator, care coordinator, referral coordinator and transitions manager as well as assist with in-person visits with the physician, increasing the nurses' personal relationship with their patients and opportunities for care coordination, while also eliminating the extra work of hand-offs between multiple role-types.

What metric- and goal-setting resources can I use?

The PCPI®, National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (**HEDIS**) and CMS set nationally recognized quality metrics and goals each year that you can use for your quality metrics. These are exhaustive lists of metrics, allowing you to select the metrics that are most relevant for your patient population and that you know can be measured in your practice without too much difficulty. You can also work with your patients' insurers to identify what goals and metrics they have chosen for their value-based plans.

3 Partner for success

Depending on the size of your practice or organization, you may need the additional resources that a partnership can offer to help you successfully shift to a value-based care model. Partnering with local hospitals, practices, urgent care centers or other organizations may enhance your ability to offer better transitional care and outpatient care management to your patients.



Q&A

How can partnering with other organizations help me improve patient care?

If you do not have privileges at a hospital, partnership with a hospital could allow you access to your patients and their records when they are seen in the ED or admitted into the hospital and provide you with the opportunity to participate in transitional planning and care. Such partnerships may help reduce inpatient admissions, ED visits and duplication of services and drive coordination of care.

Care fragmentation poses a major safety risk and can lead to patient dissatisfaction and disengagement. The hospital-practice interface is a great example of an opportunity to decrease care fragmentation through coordination and communication. A hospital partner may be able to provide discharge lists and ED visit reports that can help your practice follow up with patients and ensure continuity of care.

Partnering with home health agencies, skilled nursing facilities, pharmacies and other community resources can also help providers communicate and collaborate across the continuum of care. You may also consider partnering with an independent practice association (IPA) for the potential benefit of resource sharing. If you will be forming an agreement with a partner, you should seek legal counsel to assist you in negotiating the terms.

How do I approach a potential partner about helping us deliver value-based health services?

Even though some practices have been using value-based health care models for more than five years, it is still a relatively new concept in the health care world. Begin conversations with potential partners and payers by asking them to help you and the community make this move toward value together, for the sake of your patients. Come to the table with a thoughtful business model that you can discuss.

Why should I consider payers as partners? Which payers reimburse for value?

Partnering or aligning with payers who reward positive outcomes could result in financial compensation. Some arrangements may result in cost savings going to external partners (such as hospitals or other entities) and not always directly to the physicians. For this reason, you should have an independent legal counsel review any contracts you intend to enter into with a partner. Also be aware that for some practices, cost savings may not be achieved for several years.

Some payers will have pre-determined quality measures that you must meet prior to receiving financial compensation, and you can build these into your value-based care model. Ideally, payer contracts should be negotiated so that the metrics or measures are beneficial to both parties involved.

Payers that reimburse for value include Aetna, BCBSNC, Cigna, Coventry, Humana, United Healthcare and traditional Medicare. (Note: these programs are specific to certain locations, and different communities will have different value-based programs.) It is important to negotiate payments and penalties prior to signing contracts with each payer to ensure the metrics selected are ones that your practice can track and achieve.

What points should I consider when negotiating with payers or prospective partners?

Do	Don't
Review your practice's historical performance before starting negotiations with a specific payer or partner	Allow too much time to pass between negotiation meetings
Identify internal "must have" goals and rank them in order of importance	Be passive in the negotiations
Evaluate multiple payers and partners	Be adversarial
Be proactive and prepared	
Be collaborative	

4 Drive appropriate utilization

As the new model is adopted, look for ways to reduce unnecessary costs or variances, and drive utilization toward a lower-cost, highest-quality approach. Patients should find that their needs are being met without having to go elsewhere to receive care. Your team will be empowered to help your patients manage and improve their chronic or poly-chronic conditions, and partners may increasingly rely on your practice as the new model is adopted and refined. Through a more effective, team-based approach care, outcomes should improve and physician time can be spent on new appointments, annual visits and critical patients. Intermediate care, follow-ups and education can be provided by other members of the team.

> "By partnering and establishing trusting relationships with patients, caregivers, providers and community partners, [we] are able to improve quality of life, satisfaction with care and reduce unnecessary spending."

Dr. Edgar Maldonado, Physician, Cornerstone Personalized Life Care Clinic, High Point, NC

Q&A

What techniques can I use to identify unnecessary costs in my practice?

Working with your practice's financial expert or using analytic software to determine your high-cost spending patterns will help you identify if there are any unnecessary costs associated with your practice. Note that there may be some start-up costs associated with purchasing these programs.

Using analytic software may help you discover unnecessary costs for you and your patients. For instance, it may reveal that an imaging center used by your practice is more expensive than others in the area. After comparing the quality of services it may be prudent to start referring patients to the lower cost centers.

Other STEPS Forward™ modules may be useful in your quest to identify and eliminate unnecessary costs and improve efficiency in your practice. For example, **pre-visit planning**, **team documentation** and **team-based care** are time-saving approaches that have helped other practices reduce costs.

Can you give me some examples of unnecessary costs that practices with successful value-based care models have eliminated or reduced?

Examples include:

Cost savings opportunity	Example
Improving appropriate imaging	The practice consults appropriate use criteria before ordering imaging tests.
High-cost DME	The practice examines the cost of wheelchairs and switches to a lower-cost generic.
Unnecessary or outdated medications	The practice incorporates a **medication management system** to help patients better understand their medications. Pharmacists work one-on-one with patients to educate them on current medications and eliminate unnecessary prescriptions, thereby reducing costs.
Unnecessary or duplicate laboratory testing	The practice obtains results from outside facilities before the patient visit. Partner with a lab service that ideally has data integration capabilities to help eliminate unnecessary lab work when a patient receives services outside the practice.
Prevent avoidable hospitalizations and ED visits	The practice identifies the patient population(s) with the highest utilization of hospital and ED services and enrolls patients in **care transition programs** to decrease utilization.

Source: AMA. *Practice transformation series: prepare your practice for value-based care. 2016.*

5 Quantify impact and continuously improve

Continuously monitoring your progress will help you determine the impact you have on your target patient population. In order to achieve positive outcomes, reassess how well your practice is accomplishing the predetermined goals monthly or quarterly and adjust your efforts to continuously improve. Reevaluate your care model annually to ensure it is providing the desired impact. Regularly measure your patient, provider and staff satisfaction as these are key identifiers of your model's success.

DOWNLOAD Value-based care metrics

Keep an eye out for other value-based contracting options with payers and partners. Check your negotiated contracts on an annual basis to ensure you are using the latest evidence-based metrics and receiving appropriate financial compensation.

Each step on your journey to value-based care is a learning experience. Some decisions will work well, and some ideas will not work as planned. As these learning experiences provide your practice with more knowledge about what works best, the practice can make the changes that will better meet patient needs. Transparently and routinely informing your practice of the results of value-based care model implementation, either in scheduled team meetings or with brief recaps during huddles, can help encourage the team to stay positive and continue delivering value to patients.

Q&A

Are there some examples of metrics that other practices have used?

CMS and commercial payers can provide you with a list of metrics specific to your practice that you can negotiate for value-based reimbursement. Due to a competitive market, this type of information is typically not shared. Consider downloading and modifying the sample checklist of metrics from evidence-based medicine (EBM) guidelines to prepare for the negotiation process.

DOWNLOAD Value-based care metrics

Are there any penalties in a value-based contract if I do not achieve my goals?

Whether your practice will be penalized for not meeting its goals depends on the type of contract you applied for or negotiated with payers. For example, there are **upside-only contracts** without penalties. However, as success is achieved, you might want to transition to risk-based contracts that include potential penalties because these contracts also have the greatest potential for financial reward. Prior to signing any contracts, negotiate the gains and penalties you might receive and are able to accept. It is recommended that you work with qualified legal counsel when negotiating value-based contracts.

How can I involve patients in my new commitment to providing value-based care?

Patients must be involved and become responsible participants in their own health care. Intervening with high-risk patients between office visits with a simple phone call or connecting them with a **health coach** are ways you can engage patients in their health care. If your practice has a patient/family advisory council, involve them in your improvement efforts as well. Patients can be invaluable in helping shape the practice's value-based care model.

Upside-only contract: a contract where no penalties are assessed for failing to meet goals. Savings are typically shared evenly between the provider and the payer

AMA Pearls

Prioritize team communication when adopting the model

When developing the new value-based care model, collaborate with physicians, physician assistants, nurse practitioners, leadership and clinical staff to incorporate their insights and expertise. Huddle with your team every day to cover any gaps in care and patient goals that need to be addressed during that day's scheduled office visits. Meet as a team weekly or biweekly and include a review of panel metrics. These conversations are crucial to the success of value-based models.

Utilize data to continue to improve

Use your data to improve your care. Do not underestimate the investment in IT infrastructure, applications and database solutions required for the move to a value-based care model. When selecting a technology partner take into account their depth of knowledge in clinical and administrative processes related to care models, contracting and care coordination, not just analytics.

Design roles that empower the care team

A team-based approach to care is essential for successful implementation of a value-based care model. Create a strong team culture and empower the team to address the unique needs of each patient by using these other STEPS Forward™ resources:

- Team-based care
- Team documentation
- Pre-visit planning
- Expanded rooming and discharge protocols

Engage patients throughout the process

Communicate proactively with your patients as a provider and as a practice. Keeping patients engaged and ensuring their experiences are positive in every interaction with you and your team is critical to your success in the transition to value-based care.

Conclusion

Value-based care models are the future of sustainable health care. This module is designed to help your practice make the shift towards this model so that your patients and team can reap the benefits of this outcomes-focused approach that incentivizes high quality, patient-focused care and reduces overall health care costs.

STEPS in practice

1 How's it working at Cornerstone Health Care in North Carolina?

Cornerstone Health Care, a multispecialty group in the triad region of North Carolina, decided to make the move to value-based care in 2012. The organization transitioned from the traditional "fee-for-service" model to a patient-centered health care delivery system.

This value-based care model first implemented in a specialized heart clinic was designed to address the top 20 percent of their sickest chronic heart failure (CHF) patients. To be referred to the clinic, the patient must have an established cardiologist within the organization and meet one of the following criteria: ejection fraction < 45 % or documented diastolic dysfunction. The care model utilizes a team of three internists, embedded behavioral health provider, embedded pharmacy services, health navigator and nutritionist. A nurse practitioner and a health navigator work closely with the patient's cardiologist and other members of the health care team to create a treatment plan that is customized to the patient's individual needs. They also closely adjust medications to control the patient's symptoms and teach patients other strategies to control their symptoms. The health navigator makes calls between visits, monitoring the patient's progress closely and addressing any health care concerns.

After implementation, the team closely monitored the impact of this care model. The model started out as a separate clinic managed by a nurse practitioner that thrived on referrals from cardiologists and primary care providers. Ideally, the physicians would refer a patient to the clinic to help manage the patient's chronic heart conditions and to offer additional resources (pharmacy, behavioral health, nutrition, and social work) outside a typical office visit, all under the supervision and expertise of a nurse practitioner.

One of the struggles experienced with this model was the process of internally referring patients to the clinic, which involved transferring care to the heart function clinic from the traditional office practice of the physicians. The physicians resisted referring patients to the clinic because they saw referrals as a sign of "giving up" on their patients rather than co-managing their care. Another barrier was the additional copays that were required for each billable service provided. After a referral to the clinic, some patients refused to schedule follow-up office visits with the nurse practitioner because their insurance required this additional copay.

Despite these early challenges, savings on a per-patient basis were astounding as a result of greatly reduced numbers of hospitalizations. However, a certain enrollment number was necessary to offset operational costs. The organization struggled to approach this enrollment number for multiple reasons, including patients who exited the program and difficulties in securing referrals. For this model to achieve cost savings, and to break even, the clinic needed significantly more patients to be enrolled in the model. The current workflow was not achieving this, so Cornerstone began a redesign phase to address these and other issues. The team had to rethink the workflow and enrollment criteria to encourage physicians to refer patients to the clinic and increase patient enrollment. The organization is currently negotiating with their full-risk contracts to appropriately waive copays for qualified high-risk patients, and the team is engaging physicians to identify the best possible workflow for co-management of care.

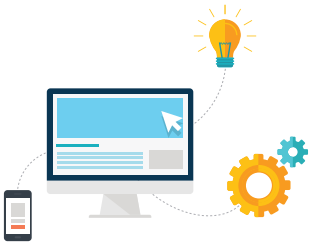
Despite the struggles and slow enrollment, this care model has had a great impact on their patient population and cost of care. In the three years since implementation, this care model has seen a per-patient cost of care savings of $5,500 and overall cost of care savings of $1.7 million for the 321 patients enrolled in the program. Most of these savings are based on comparing the total cost of care for the patients before they entered the program and their total cost of care after enrolling in the program. A reduction in hospital admissions because of improved outpatient management is the critical factor in the overall cost savings.

Cornerstone now has six specific care models to address their most vulnerable patient populations, and since implementation, they have seen positive outcomes resulting in more than $3,000 per patient savings and more than $6 million dollars in total savings on a total of 461 patients. They have also increased their patient and provider satisfaction by 43 percent and have a quality score of 94 percent, ranking them 6th in the nation.

To demonstrate completion of this module and claim *AMA PRA Category 1 Credits™*, please visit:
www.stepsforward.org/ValuebasedCare

Get implementation support

The AMA is committed to helping you implement the solutions presented in this module. If you would like to learn about available resources for implementing the strategies presented in this module, please call us at (800) 987-1106 or click here to send a message to StepsForward@ama-assn.org



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