Future-Forward Improvements in Quality Healthcare

Innovative Metrics, Payments & Plan Design

Written By Laura Carabello

Quality healthcare is an evergreen topic that appears to take on new parameters year after year.

As self-insured employers face unprecedented healthcare costs in 2023 and reflect upon some uneven patient experiences and satisfaction with care during the past year, they are counting on value-based payment and direct contracting models for improved quality and better outcomes.

Employers now realize that they can use their purchasing power to negotiate arrangements that tie provider reimbursements to the quality of care -- not the quantity of services -- and get 'healthier' results at lower costs.


Shane Purcell, MD

This is precisely where direct contracting is pivotal to achieving improved quality, as explained by Dr. Shane Purcell, MD, Direct Access MD who offers this perspective,

"Directly contracting with a primary care physician – known as Direct Primary Care -- allows for more access and time, which are critical for proper care. Primary care is about building relationships…heck, all of medicine is built on relationships. While quality like beauty is in the eye of the beholder, studies show patients do better with strong relationships with a primary care physician. The only way to build trust and relationships is time, which DPC offers."

Fundamental to this approach is the belief that when practices draw on the expertise of a variety of provider-team members, patients are more likely to get the care they need. A large provider team that is part of an ACO or health system under direct contract might also support continuous, data-driven quality improvement through effective intra-team communication and problem solving.

When the key driver of financial success is keeping patients healthy – rather than billing for services – providers are more inclined to deploy team-based care: broadly defined by The Institute of Medicine (IOM) as "the provision of health services to individuals, families, and/or communities by at least two healthcare providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care."

Team-based care offers many potential advantages for employer groups that are concerned about absenteeism related to accessing care, including:

- Expanded hours of coverage, shorter wait times
- More effective and efficient delivery of additional services that are essential to high-quality care, such as patient education, behavioral health services, self-management support
- Care coordination
- Increased job satisfaction
- An environment in which all medical and nonmedical professionals are encouraged to perform work that is matched to their abilities.

The voice of providers and health systems regarding direct contracting is indicative of the support and traction it is gaining in the marketplace.

To this point, Sandy Balwan, MD, chief medical officer, Northwell Direct, shares, "Direct Contracting strategically places employers in the driver's seat by eliminating the middleman and allowing for direct negotiation of rates for health care services.

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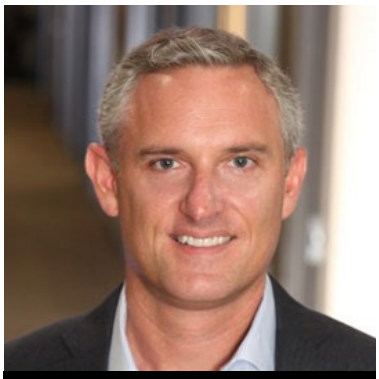
Sandy Balwan

Armed with additional dollars garnered from discounted rates, employers are empowered to improve the quality of care and health outcomes for their employees through investing in preventive services, wellness and disease management programs. Further, the current competitive healthcare landscape drives healthcare systems and provider groups to compete for patients, thereby incentivizing them to raise the ceiling on the quality of care delivered now and in the future."

Since quality is widely perceived as a crucial aspect in provider direct contracting strategies, Mac Meadows, president 90 Degree Benefits – Houston, says it is often the central point of negotiation between parties.

"Health systems may demand steerage and exclusivity in exchange for competitive rates, while employers require the health system to demonstrate measurable quality in terms of patient experience and outcomes, in order to justify a narrowed network for members," says Meadows.

"This dynamic creates a need to seek direct contracts with providers who consistently deliver high-quality care. By doing so, all parties can be assured that their goals of cost-effectiveness and optimal patient outcomes are met."



Mac Meadows

DEFINING QUALITY

As Ashley Rutkowsky, Independent TPA Consultant, points out, "The concept of quality can be multifaceted, depending on the specific needs of a plan. For instance, an employer-based plan might place a premium on patient experience in order to boost employee satisfaction and retention. Conversely, a plan may prioritize cost-efficiency for providers, in order to remain financially viable during leaner years. In either case, the ultimate goal is to achieve positive outcomes for all stakeholders involved."

Ashley Rutkowsky

As employer plans often tout the importance of quality in their mission statement regarding healthcare benefits, actualizing this goal can prove challenging for a number of reasons.

Scott Bennett, senior vice president, Provider Relations, The Phia Group, explains that one issue is the lack of standardization in quality metrics for health systems, which can vary greatly depending on the factors prioritized in their assessment.


Scott Bennett

"Additionally, outcomes can be highly individualized, based on factors such as patient characteristics, procedures, and staff," says Bennett. "This makes it difficult to predict the experience of any one individual. Finally, the goal of quality can sometimes conflict with the budget constraints that employers face, as members may expect a higher-quality, and therefore more costly, experience even when the health outcome remains unchanged."

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Quantifying Healthcare Quality

While there are many bodies and organizations that measure healthcare quality, the regulation is fragmented between government agencies, provider, and health plan sponsored organizations.

"With this fragmentation, plan sponsors are at risk for inadequate quality of care information flows resulting in adverse patient events and increased costs," advises Jakki Lynch RN, CCM, CMAS CCFA, director of cost containment, Sequoia Reinsurance Services, who describes these burdens further in this article.

There are many definitions of healthcare quality but the Agency for Healthcare Research and Quality (AHRQ) denotes six domains, with measures that can be combined and leveraged differently in varying value-based care arrangements. The following provides an overview of these critical areas for value-based care success, as many employer purchasing contracts require that certain quality measures must be met before payment:

1. Effectiveness and Efficiency

A joint effort that centers around ensuring that hospital patients receive proper care and the resources to coordinate future care to reduce readmission rates. Many value-based care contracts assess whether or not the provider has taken the appropriate steps to deliver a level of care that could have prevented readmission barring extenuating circumstances.

2. Timeliness

Providing prompt patient care can positively affect patient experience and increase quality of care. Difficulty making appointments, or long wait times to get in for an appointment, can negatively affect patient experience and hinder patient care. Delays in care create challenges in fulfilling the tenants of value-based care models and can hinder the preventative aspects of the model.

3. Safety

Quality care means safe care. Patient safety models are incorporated into value-based care models for obvious reasons, since a major emphasis in these systems is on prevention.

4. Patient focus

Patients want to feel like they are being listened to and that their providers care about their health and well-being. Patient-centered care checks off these boxes to provide a more fulfilling patient experience. This can also come as a result of increased patient compliance and more effective coordination of care, which is rewarded by value-based care models.

5. Equitability

A tricky quality measure to evaluate quantitatively, equitability is nonetheless critical in value-based care models. Equity quality measures encourage providers to provide care to patients from every portion of the population, regardless of demographic. An important consideration in healthcare equity includes understanding and addressing social determinants of health, such as the economic status of patients.

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NEW JOINT COMMISSION REQUIREMENT: HEALTH EQUITY BECOMES A NATIONAL QUALITY & SAFETY GOAL

Increased awareness of health equity issues and their impact on quality has led business leaders and employers to ask what more can be done to address health disparities. Many have taken meaningful steps toward improving the outlook, buoyed by a recent announcement from The Joint Commission (JC).

JC issued new and revised requirements that upgraded health equity as a leadership standard that is included in the national patient safety goal (NPSG 16), effective January 1, 2023.

Under NPSG 16, accredited hospitals will still be required to focus on social disparities by identifying patients' needs and disparities and developing a strategic plan to improve health equity in their organizations. But the new change is significant, underscoring the importance of health equity and encouraging hospitals and health systems to view disparities as a quality and safety priority.

Craig Parker, JD, CPA, CEO

"We are pleased to see the Joint Commission take action to further elevate the importance of health equity," says Craig Parker, CEO of Guideway Care. "After all, access and understanding are the foundation for safety and quality of healthcare."

He points to a proven approach of utilizing care guidance to promptly address the physical, practical, emotional, informational, cultural, spiritual and familial barriers that impact patients – issues that directly affect quality of care in direct contracting arrangements.

With scalable and repeatable interactions between patients and those who guide the care, supported by a structured care guidance platform, this approach captures and communicates relevant data back to the clinical team, such as those data elements that meet the new Joint Commission requirements and can potentially be shared with the employer.

The value extends to resolving barriers to accessing care that are completely distinct from clinical issues, which becomes critically important for capturing Social Determinants of Health data and disparity-related barrier resolution.

It leverages the capabilities of non-clinically trained individuals to facilitate operational improvement by seamlessly escalating clinically relevant information while delivering SDoH insights for each patient population. It also alleviates any concerns about Electronic Health Record (EHR) systems that are generally not specifically designed to facilitate the kind of resolution workflows that are needed when addressing health equity and social determinant issues.

Joint Commission president and CEO Jonathan Perlin, MD, PhD says, "By elevating the existing standard to a National Patient Safety Goal, we are emphasizing the importance for healthcare organizations to ensure oversight and accountability for healthcare equity. The new National Patient Safety Goal will help increase the focus on improving healthcare equity, a global patient safety priority."

PROVIDER DIRECT CONTRACTING WITH CARE MODELS THAT ENSURE QUALITY


Brandon Burket

In their quest for quality healthcare and cost predictability, employers are adopting a direct contracting strategy that incorporates robust financial incentives to manage the cost of care for all parties —employers, providers and employees —while delivering enhanced clinical outcomes for patients.

This approach establishes a one-to-one relationship between a health system or a provider network and a self-insured employer, with employers assuming the financial risk and responsibility of paying their employees' medical claims.

Typically, the employer contracts with third parties for enrollment, claims processing and provider network construction. According to a recent survey by the Business Group on Health, nearly a quarter (24%) of all employer healthcare purchasers are considering contracting directly with integrated delivery systems.

"An immediate benefit of direct contracting is the enhanced ability of the consumer to better align their aspirational goals with the capabilities of participating provider organizations," says Brandon J. Burket, MHA, vice president, Orlando Health, Value-Based Care & Population Health. "In the traditional model, third party involvement can frequently produce inefficiencies, thereby generating waste (effectively, increased costs to the consumer) without measurable improvements in performance, such as better quality outcomes and patient experiences."

He points to the strength of a direct relationship between the purchaser and provider of services as a key factor in removing such extraneous and, oftentimes, competing interests from the equation to allow organizations to jointly define what "value" means to them.

"Once fully aligned on this principle, organizations can turn their collective vision into reality more quickly through a direct partnership than through conventional models which tend to leverage "one size fits all" approaches for their clients," continues Burket. "This can translate to the co-development of population-tailored clinical programs, demographically-relevant quality measures, and win-win-win economic terms to create financial advantages for the patients, employers, and providers alike."

George Stiles

George Stiles, president and COO, Planned Administrators, Inc. sees direct contracting as another way to help clients customize a health plan that best meets their needs.

"We are especially excited about opportunities to partner with direct primary care providers (PCP) who share our goal of providing the best care at a reasonable cost," says Stiles. "When the PCP 'owns' the patient relationship and is focused on getting them the best care both inside and outside of their clinics they can have a real impact on care quality, which should be supported through data exchanges and streamlined referral processes. This is especially important when the primary care physicians is not beholden to a single health system for that care."

MODELS OF CARE FOR DIRECT CONTRACTING

Quality is at the heart of this value-based strategy, as employers are eager to move to these payment models. The Business Group on Health, which advocates for large employers in health care policy, points to several models of care that represent opportunities for quality healthcare value purchasing:

Direct Primary Care
DPC gives family physicians a meaningful alternative to fee-for-service insurance billing, typically by charging members a monthly, quarterly, or annual fee. This fee covers all or most primary care services including clinical and laboratory services, consultative services, care coordination, and comprehensive care management. Simply stated: DPC practices charge a flat recurring membership fee instead of billing insurance, eliminating the associated red tape and allowing physicians to build rapport with each member.

These DPC practices shift the focus of primary care toward quality instead of simply focusing on numbers, allowing providers to be free of traditional time constraints due to the need of seeing a high volume of patients.

In turn, this allows clinicians to spend more time with patients at the point-of-care and provide

more comprehensive care to patients throughout the health care journey.

Think of the positive impact this has on quality when, for example, a patient needs to be referred to a specialist for more additional services.

DPC practices have the ability to maintain a strong, ongoing relationship with patients and ensure that the care delivered is thoroughly coordinated throughout the treatment process. The improved effectiveness of primary care at the population level not only improves quality, but also leads to substantial decreases in costs.

Because some services are not covered by a monthly fixed fee, DPC practices often suggest that members acquire a high-deductible wraparound policy to cover emergencies, or another insurance alternative option that will protect members in the case of necessary surgeries, hospitalization or a large medical claim.

John Halsey

John Halsey, founder and chief growth officer, Recuro Health, observes,

"Employers are seeking quality healthcare and cost predictability and are adopting a direct contracting strategy for primary care that incorporates robust financial incentives to manage the cost of care for all parties – employers, providers and employees – while delivering enhanced clinical outcomes for patients. This approach establishes a one-to-one relationship between a provider group or primary care provider network and a self-insured employer, with employers assuming the financial risk and responsibility of paying their employees' medical claims. Typically, the employer contracts with third parties for enrollment, claims processing and provider network construction."

He notes that when employers opt for self-funding their benefits, they essentially break ties with traditional health plan payers and find themselves without access to networks for care delivery.

"Employers should be seeking value partners that provide a virtual first approach to engage the members at a lower cost while ensuring access to quality care – including preventive care to treat chronic disease on the front end and more proactively."

Halsey points to the role of narrow networks that are isolated from traditional health plan networks and will remain with the employer regardless of any changes in the major medical network.

"With this approach, when the employer changes networks, members won't have to reestablish a relationship with a new primary care physician," he says. "Ideally, the provider network runs outside of the hospital-owned primary care practice, further lowering costs by steering members towards higher performing services."

HIGH PERFORMANCE NETWORKS

Providers in a true high-performance network consistently deliver both lower costs and higher quality through care that is patient-centered, evidence-based, appropriate and coordinated – not simply lower costs. Robust data-sharing and effective quality measurement are also critical in identifying providers that deliver quality care at a lower cost.

According to the Willis Towers Watson 23rd Annual Best Practices in Health Care Employer Survey, roughly 16% of larger employers have built a "high-performance" network into their health plan, a number that is projected to grow in the coming years as these networks evolve and mature. Since these networks differ substantially in quality and cost, it's important for employers to identify the measurement metrics used.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

An ACO is a group of doctors, hospitals and/or other health care providers who come together voluntarily to give coordinated high-quality care that improves the care delivered to patients.

These organizations help doctors and other health care providers understand an individual's health history and confer with one another about care and health care needs.

This model can save employers time and money by avoiding repeated tests and unneeded appointments and may make it easier to spot potential problems before they become more serious—like drug interactions that can happen if one provider isn't aware of what another has prescribed.

The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

CENTERS OF EXCELLENCE (COE)

A COE is a hospital or healthcare facility where patients continually return to receive primary care or treatment for acute conditions, separate from the place of diagnosis. Such facilities are often epicenters of care provision for large patient populations and are thereby an example of best practices within a distinct specialty.

COEs aim to reduce variation in quality and cost and increase the likelihood of optimal patient outcomes. Quality improvements and decreased costs result from improved professional care coordination, team attention to evidence-based guidelines, better discharge planning to avoid preventable readmissions, increased uniformity of practice and measurement and feedback of patient outcomes.

Early initiatives, such as the center of excellence (COE) program adopted by Lowe's, Walmart, and others, targeted specific high-cost surgical interventions, incorporating the use of high-quality health care entities and bundled pricing to optimize outcomes while ensuring predictable case costs.

Similarly, organizations with geographically consolidated workforces, such as Boeing and Microsoft, have partnered directly with local integrated delivery networks for comprehensive care delivery.

Another example: in 2013 the Purchasers Business Group on Health established the Employers Centers of Excellence Network (ECEN) to support value-based purchasing among its members. ECEN provides employees access to demonstrated high-quality care for elective surgeries at meticulously selected COEs across the United States.

Through the ECEN, patients receive care at little or no cost, and their employers gain predictable health care costs and downstream savings. The ECEN program initially selected hospitals and surgeons throughout the nation for hip and knee replacements and later expanded to offer spine and bariatric procedures and certain oncology services.

With 96,000 members representing both individuals and organizations, the Healthcare Financial Management Association (HFMA) helps its members to achieve optimal performance by providing the practical tools and solutions, education, industry analyses, and strategic guidance needed to address the many challenges that exist within the US healthcare system.

In the COE direct contracting model, HFMA defines the responsibilities of each party:

For employers, the model offers cost savings and cost predictability via a bundled payment for a defined episode of care. For example, an employer might contractually secure a flat rate of $30,000 for knee arthroplasty at an orthopedic surgery COE. In addition to reduced costs, the employer enjoys the potential benefit of faster return to work for employees.

Blake Allison

For providers, the future-state COE model secures additional patient volume via contractual provisions that deliver a degree of exclusive access to the employee population. Providers may also be able to earn incentive payments for meeting contractually defined quality indicators.

For employees, going to a COE provider means their out-of-pocket costs are fixed. Also, by enjoying access to a provider that performs services at or above clinical best-in-class standards and that tracks clinical quality outcomes, employees are assured of having the best opportunity to recover as quickly and fully as possible.

Further underscoring the benefits of direct contracting, Blake Allison, CEO, Employers Health Network (EHN), shares, "Direct contracting allows for the buyers, the self-funded employers, and the sellers, the providers of healthcare services, to work more directly to drive true innovation and performance. When the two parties are connected via a third party, specific rules typically accompany the relationship that are designed to value the third party, not the two key stakeholders.

Jakki Lynch

Allison emphasizes that direct interaction allows for the measurement of specific, outcome-based measures, drives performance and ensures that the value of the healthcare delivery system directly impacts the employer.

"The current system has evolved to create value for the intermediary, leading to a lack of measurable performance and overall dissatisfaction," he concludes.

REDUCING THE BURDENS OF MISDIAGNOSIS, MEDICAL ERRORS

Alerting employers to the impact of misdiagnosis on the quality of care, Jakki Lynch offers this important perspective:

"This is a timely concern for plan sponsors as errors in health care delivery lead to missed, delayed or incorrect diagnoses, higher costs and unnecessary injuries and deaths. A new report published by US Department of Health and Human Services' Agency for Healthcare Research and Quality found that nearly 6% of the estimated 130 million people who go to US emergency rooms every year are misdiagnosed. The researchers estimate that 7.4 million misdiagnosis errors are made every year, 2.6 million

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people experience a harm that could have been prevented, and another 370,000 are permanently disabled or die because of the misdiagnosis."

She further reports on new data released by the CDC that several healthcare acquired infections (HAIs), such as central line-associated bloodstream infections and ventilator associated pneumonias, showed increased prevalence in 2021.

"Preventable hospital acquired conditions continue to have a huge economic burden on the healthcare system and they negatively impact overall healthcare expenditures," explains Lynch. "According to a recent 2022 study published in the Journal of Patient Safety, "Cost of Health Care-Associated Infections in the United States" estimates for HAIs ranged from 7.2 to 14.9 billion dollars."

Plan sponsors need visibility and a solution-oriented approach to identify, track, report, and manage costs for complex risk from quality-of-care events.

"Although health plans may have payment policies that address these issues, many do not have processes to identify them and adjust claim payments," continues Lynch.

Employers should keep in mind that charges incurred for preventable events should not be paid and hospitals will consider charge adjustments if presented with adequate documentation and clinical record support by payment integrity specialists.

"Plans can successfully implement a comprehensive payment integrity program to identify and mitigate significant charges associated with unexpected hospital acquired conditions and quality of care events," advises Lynch.

QUALITY FOR THE FUTURE

Jon O Toole

The National Committee for Quality Assurance (NCQA) offers recommendations that represent a vision for evolving the current quality measurement ecosystem while maintaining its most effective elements. A few key themes recur:

- The importance of refining and developing quality measurement to help stakeholders drive toward health equity and address social determinants of health.
- The potential to reduce burden and improve care by moving to a digital quality measurement system that captures quality data during care delivery and provides results and decision support much more rapidly.
- The essential role of data validation to ensure accurate payments in value-based models.

Just like beauty, quality healthcare may well be in the eyes of the beholder. Employers need to be the final arbiters of quality, how it will be measured and how they can access care that meets these expectations.

RE-ENERGIZE YOUR FOCUS ON QUALITY

"Quality" will be a key focus of a spectacular line-up of speakers at the SIIA Spring Forum, March 29-31, 2023 in Orlando Florida.

Expected to participate at the largest gathering of senior-level self-insurance industry professionals for the first half of 2023. You will have the opportunity to attend and participate in sessions focused specifically on what self-insured payers and their business partners need to know about how to better assess and leverage health care quality for the benefit of plan participants and plan sponsors.

Register Now: https://siiaconferences.org/springforum/2023/register_now.cfm

Session: Cost, Quality, and Acuity in Negotiations and Navigation

Moderator: Scott Bennett -- Phia Group

Speakers: Mac Meadows -- 90 Degree Benefits; Ashley Rutkowski -- Borislow

Session: Direct Primary Care – Connecting the Dots for Quality Care

Moderator: George Stiles -- PAI

Speakers: Jeffrey Gold – Gold Direct Care; John Collier – Proactive MD; Shane Purcell -- Direct Access MD

Session: Health Systems, Direct Contracting and Quality of Care Considerations

Moderator: Blake Allison -- Employers Health Network

Speakers: Sandy Balwan – Northwell Health; Brandon Burket – Orlando Health; Thomas Caven – Ascension

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