# Practice Transformation

It is time for healthcare providers to transform into practices that are able to deliver better care at a lower cost with higher patient satisfaction—the Triple Aim. This is what payers—both private and governmental—want. They have no other choice, as we shall see. Those providers who understand this and are willing to work with payers to meet these goals will probably be more successful as time goes on. The practice transformation will be long and hard but those who are willing to 'perspire' while focusing on the Triple Aim will succeed and the staff, both clinicians and support staff, may enjoy the journey as their patients become healthier.

It is my goal in this newsletter to explain why the transformation is necessary and to share some ideas about the ways that a practice may take in order to succeed. In newsletters in 2018 I will also address some other approaches that practices can take to be successful. Some of these will be based upon my experiences in helping clients to transform and others will come from literature that I read frequently as well as from my contacts with local provider networks.

In the late 1970's and in the 1980's payers began contracting with providers to form HMO's. The hope was that they could reign in the ever-rising costs of providing care. These costs were being passed on to businesses that provided health care to their employees and families as well as to individuals. Payers contracted with providers whom they thought could provide better care at lower costs. This arrangement did not work and patients were upset that they could not see providers of their choice. Costs continued to rise for payers and the costs of contracts with businesses continued to rise steadily. Businesses reacted by raising deductibles and copays in their contracts; more costs were shifted to employees and individual buyers. This rise in costs to individuals has continued to the present. One of the problems with HMO's and other narrow networks then was that physicians were still being reimbursed as fee for service without much regard to quality of care. Today, the continued rise of costs to businesses and individuals cannot be sustained or only the very well-off will have good healthcare coverage.

Because the old models of insurance were no longer viable, private payers began to switch to paying for value in care provided. Some of the first examples of switching to value-based care were bundled payments for joint replacement surgery and the formation of Accountable Care Organizations. Two acts from the U.S. Congress also encouraged the gradual change to value-based care contracts. The first was the Accountable Care Act. This forced payers who sold products on the state insurance exchanges to pay for a minimum set of provider services and to provide preventive services at no charge to the patient. The act also established a web site that compared the value of different plans on the exchanges so that customers could purchase the plans with the best value. Businesses also purchased plans with at least the minimum amount of services.

MACRA (the Medicare Access and CHIP Reauthorization Act) starting in 2017 pressured providers to transition to providing services based upon value. Value indicators were established by the act and some of the reimbursement to physicians was based upon achieving benchmarks that are annually defined.

I think you can see that for the foreseeable future private payers will continue to contract with providers based upon the value of services provided. Providers that provide the best services for the lowest costs will succeed with these payment models.

In my locale, Mercy Health of West Michigan and Blue Cross Blue Shield of Michigan have contracted together to provide care and an insurance product that is very affordable to individuals, including a Medicare Advantage product. Buyers of this product must use Mercy Health Physicians and one of four hospitals in the area. Mercy Health is able to deliver the quality of care that Blue Shield desires as Mercy Health physicians have been certified at level 2 or 3 NCQA Patient-Centered Medical Homes for quite some time. NCQA PCMH's have been shown to meet the Triple Aim. Mercy Health physicians have worked hard many years to achieve their certification as patient-centered medical homes. Blue Cross and Blue Shield have enhanced their reimbursement for having done so.

For primary care providers becoming certified as a PCMH makes sense economically, according to the article "PCMH accreditation: Is it worth it?" online at medical economics. There are several different organizations that certify primary care sites as medical homes. In Michigan Blue Cross Blue Shield has been certifying sites as medical homes since 2009. Practices that qualify received enhanced reimbursement for services, as did Mercy Health physicians. NCQA, a federal department, also certifies sites as PCMH's nationally. I think that any primary care provider should explore becoming certified as a PCMH by checking with the payers with whom they are contracted to see if there is additional reimbursement. CMS is considering expanding their definition of PCMH to include other certifications outside of their current demonstration project so additional practices can qualify for enhanced reimbursement under MIPS.

Another approach to reaching the Triple Aim is to focus on social determinants of patients. These include cultural background, income level, gender, age, etc. This approach is recommended in the article "Building a Population HEALTH Strategy that Physicians LOVE" in the October 2017 edition of *MGMA Connection.* Practices should focus on social determinants in order to overcome barriers to good health that an individual may face. Sometimes this will mean that a practice will want to have relationships with local non-profits that are able to provide resources for their patients that will influence the outcomes of the care that the provider gives. Two such agencies that I have experience with that I think would be useful are Meals on Wheels and The Salvation Army.

I recently visited my local Meals on Wheels program and found that one of their primary goals is to help their clients stay in their homes rather than being admitted to assisted living. Clients of Meals on Wheels have limited mobility and have difficulty preparing their own food, besides having limited income. By providing nutritious meals every week to clients, the clients are able to stay in their own homes, which they value. Also, volunteers who deliver the meals are instructed to keep an eye out for any changes to their clients' health and report it.

I also went along with a registered nurse from Meals on Wheels to a client assessment at the client's home. The nurse not only collected information about income and family support, but also extensive information about the general health of the client, including number of falls in the past year. From my experience, I believe that a healthcare group may want to formalize a

relationship with organizations such as Meals on Wheels as doing so may help in maintaining or improving the health of patients who are clients of such organizations.

Recent history shows that the fee for service model will be disappearing, at least in part, and replaced by value-based care. It will not be known for quite some time whether this new reimbursement model will have a significant impact in slowing down the rise in healthcare costs. Patient-centered medial homes have shown that costs can be reined in while care is improved. For the immediate future providers need to focus on the transformation to value-based care organizations and explore local resources that may be able to help their patients overcome barriers that impede the care that they provide.

For another perspective on the transformation of healthcare to value-based organizations, you may want to read the article "The Road to Affordability: How Collaborating at The Community Level Can Reduce Costs, Improve Care, And Spread Best Practices" found in the *Health Affairs Blog* of November 14, 2017. It has some good examples of the transformations going on in other parts of the United States.

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