Clinical Redesign: Key To Shifting From Volume To Value

This is the first in a series of articles that will address the impact of various value-based programs and how hospitals and health systems should respond to stay competitive. This article summarizes the current landscape and sets the stage for future posts that outline specific strategies and tactics involving clinical redesign and reducing clinical variation as central to increasing value.

A tremendous amount of uncertainty surrounds the health care industry in the beginning of the new Trump administration. Repeal and replace plans are still in development, with opinions varying widely as to the final shape and impact of new executive orders and legislation. Although early, there is a consensus emerging that the shift away from fee-for-service towards value, which began under the ACA, will likely continue. In fact, on January 25, a coalition of over 100 industry leading organizations including the AHA and AMA sent a letter to the new administration to this effect.

The letter includes the following statements: "We are writing to underscore our commitment to advancing the highest quality, most cost-effective healthcare system in the world… We call upon Congress and the Trump Administration to help us achieve this goal… Through private and public sector alignment, the move toward value-based care is succeeding, measurably improving healthcare quality and contributing to historically low costs… Now is not the time for policymakers to signal a shift away from value-based care, either through action or inaction." The coalition's letter also indicated support for MACRA's Quality Payment Program for clinician Part B payments.

Recent surveys provide additional data points in support of the continuation of the shift to value, showing hospitals are generating approximately half of their revenue from value-based contracts.

We recently asked a large group of CMOs if any of them believed growth in funding for Medicare and Medicaid would continue unabated. None answered in the affirmative. In fact, there was broad consensus that the best course of action is to, as Tom Peter's would say, "stick to the knitting". In other words, in the face of ambiguity, focus on what you can control, and on what you are already good at. For the majority of hospitals and health systems that means reducing costs and increasing quality. A necessary response to the changing expectations of public and private payers, large regional self-insured employers and more consumer oriented patients and their families. So one thing is clear. Although the shift to value will likely continue, even if it does not, the pressure on the industry to increase quality and reduce costs will continue to increase. So the question becomes, how should hospitals and health systems respond?

In our experience, the vast majority of our hospital and health system clients have undertaken cost and quality improvement programs targeting labor, non-labor, pay practices, and LOS. Many

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have made significant improvements in performance, but those have not been enough to effectively operate in the value based world. Furthermore, many clients are attempting to achieve across the board Medicare break even cost structures. To achieve this goal, hospital and system executives are going beyond traditional improvement approaches and are beginning to redesign clinical processes to reduce care variation. This is a difficult undertaking even if focused only on the acute care setting (see Novia's article on the Keys to Successful Clinical Redesign). Yet the changes are now even more complex, requiring an examination and improvement of the full continuum of care encompassing post-acute care providers as well.

The remainder of this series of posts will address how Clinical Redesign is the last frontier of performance improvement and how it can be used to ensure care delivery processes deliver value. Three recent programs from the CMS put a spotlight on the shift to value and the need to improve the full continuum of care: The Comprehensive Care for Joint Replacement (CJR) program, MACRA's Quality Payment Program for physicians, and the Episode Payment Models (EPMs) which will bundle cardiac services (among other changes). Future articles will summarize: 1) the impact of these programs on acute care hospitals, 2) how Clinical Redesign is the most effective response, and 3) the specific steps you can take to apply Clinical Redesign principles throughout the full continuum of care.

About the Author

John Malone is a Vice President with our sister company, Novia Strategies. Novia Strategies is one of the longest-established clinician-owned healthcare consultancies in the country. The firm provides a variety of services designed to reduce costs and improve quality, including clinical redesign, care management, non labor, staffing and productivity, compensation and benefits, surgery, pharmacy, technology and revenue cycle.

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