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BUILDING THE CARE DELIVERY MODEL OF THE FUTURE



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Building the Care Delivery Model of the Future

Authored by:

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With organizations exploring bundled payment pilots and conducting ACO readiness assessments in preparation for the implementation of health care reform, the importance of an effective and efficient care model has never been greater. Health care reimbursement mechanisms of the future will almost certainly result in higher levels of provider accountability for the costs and outcomes of care. Moving to the new world of managing transitions across the continuum, chronic diseases and the health of a population requires a foundational set of competencies and structures that many organizations lack today.

With local markets evolving at different speeds, many providers have a window of opportunity to leverage current reimbursement dynamics to fund advances across four core dimensions:

- **Alignment of Clinical Resources into Multidisciplinary Care Teams:** Organizing scarce clinical resources, including physicians, associate providers, nurses and other ancillary personnel, into an effective multidisciplinary team that takes full advantage of the skills and competencies of each individual will be a key success factor in the coming years.
- **Care Coordination:** A holistic view of the patient's plan of care is required to seamlessly coordinate care within and across settings and to monitor the patient's status and compliance with prescribed treatment.
- **Clinical Effectiveness:** Consistency in diagnosis and treatment based on available evidence is essential to reducing undesirable variations in treatment patterns and ensuring optimal patient progression.
- **Communication and Collaboration:** Fundamental to a high performing care model are a culture and set of processes that support, encourage and expect communication of information in support of shared priority-setting and decision-making among all members of the health care team.

Achieving success across these four dimensions typically requires core competencies and structures that are frequently assumed to already have been honed after years of performance improvement initiatives. Moving forward, providers will need to objectively assess their true capabilities across these dimensions and develop an improvement roadmap that balances current reimbursement incentives with the need for rapid change and a process that achieves sustained results.

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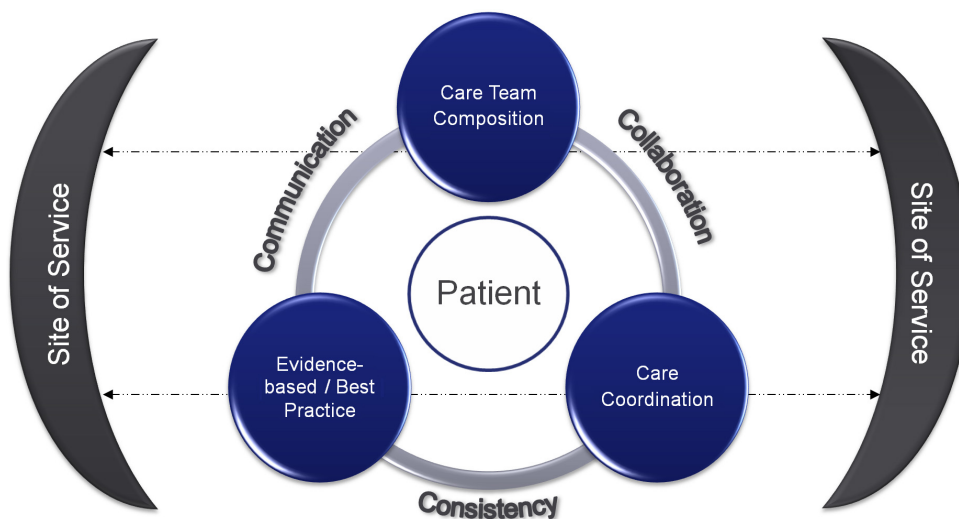
New and Familiar Challenges

The ultimate goal of health care reform, regardless of the merits of the current law, is to ensure access to the highest quality care at a price that does not bankrupt the country. Achieving the goals of access and affordability will put tremendous stress on providers over the coming years. Chief among the challenges is determining how to form effective multidisciplinary care teams, and determining the optimal role of technology in delivering effective care.

As coverage expands over the next few years, providers can expect to see increased patient volume. The dilemma facing most providers is how to optimize the composition of the care team so that it incorporates the necessary clinical expertise while appropriately leveraging physicians. Complicating this issue is the evolving nature of the physician workforce. Primary care physicians remain in undersupply and newly minted physicians across all specialties are increasingly emphasizing work-life balance, further reducing the size of the physician workforce. As a result, associate providers, including advanced practice nurses and physician assistants, are likely to play a more significant role in health care delivery moving forward. The increased use of advanced practice nurses, in particular, will force providers to confront the issue of funding and expectations. Variation across states regarding scope of practice and billing has contributed to role confusion in many organizations, leaving advanced practice nurses underutilized from a competency and revenue-generation standpoint.

Across all sites of service, providers need to think about how to support care teams with processes and technology that fosters communication and collaboration with teams in other settings (*Figure 1*). In the inpatient site, providers still struggle with basic rounding processes that bring a multidisciplinary team together on a daily basis to develop a patient's plan of care and monitor progress against it. With teams struggling to work effectively with each other, collaboration with teams in other settings generally occurs as an exception rather than as the standard of care. Accordingly, many providers have increasingly moved to hospitalist models in general medicine

Fig 1: A Framework for Patient-Centered Collaborative Care Delivery



to standardize care and improve throughput. Hospitalists have also allowed generalist physicians to remain in the ambulatory setting and increase access for patients seeking care. The model has been extended to obstetrics with the laborist model and is likely to find its way into other areas as providers continue to seek mechanisms to leverage specialists.

While the hospitalist model has created the opportunity to vastly improve communication within the inpatient setting by providing consistency and improving availability to other members of the care team, it also tends to fragment communication across settings. In the past, physicians would generally follow their patients from the inpatient to the ambulatory setting; however, the hospitalist model creates a built in hand-off between settings. An ongoing criticism of some hospitalist practices is the delay in communicating information back to the referring physician about the status and treatment of patients, particularly with physicians who are not in the same group practice or on the same technology platform.

In the ambulatory setting, providers have worked to improve patient access to care, in many cases by supplementing physicians with advanced practice nurses and physician assistants, but have not necessarily focused on ensuring that patient transitions between settings occur smoothly. Even in today's wired world, physicians often do not have access to a patient's record in a timely manner. As a result, relatively little coordination and follow-up occurs when a patient transitions between settings to confirm that the patient is complying with the prescribed treatment and that the treatment is efficacious.

Heavy emphasis has been placed on information technology systems, particularly electronic medical records, not only to standardize documentation and improve patient safety, but also to make information timelier and more widely available to clinicians. For most providers, electronic medical records have indeed brought tremendous benefits; however, the technology has also produced a few unintended consequences. The ability of clinicians to view patient information and enter orders from any location has effectively reduced communication amongst all members of the care team and made it more difficult to ensure that the care team shares a common understanding of the patient's plan of care. Additionally, standardization of the medical record has also sterilized it to some degree making it more challenging to gain a holistic view of the patient without direct conversation. In essence, current technology has increased the need for direct communication and collaboration amongst the members of the multidisciplinary team.

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Focusing on the Basics of Care Delivery

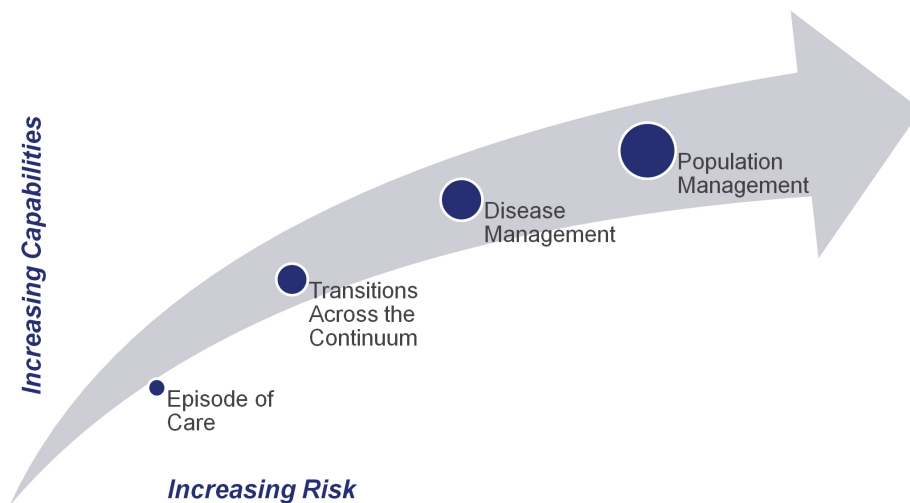
The improvement roadmap for most providers must include a back-to-basics approach to care delivery as new structures and processes are designed and implemented to handle increasing amounts of risk. Although bundled payments and capitation may represent the financial future, the present for many providers still consists of incentives that emphasize episodic management of patients. As such, improving patient throughput and increasing volumes in all settings should allow providers to increase revenue and return on assets, while at the same time laying a

solid foundation for the future care delivery model. Many of the capabilities required to manage throughput are the same capabilities, particularly communication and collaboration, which providers must advance as they begin to take on more risk. Understanding the causes of suboptimal throughput is a valuable component of assessing the entire scope of work required to build more sophisticated capabilities in care delivery as a whole.

The next frontier in care delivery for most providers will be managing transitions across the continuum (Figure 2). Even now as CMS begins to withhold payment for readmissions and certain complications, providers are incented to more tightly coordinate care as patients move within and across settings. Despite the potential for information fragmentation across settings, providers should continue to broadly extend the hospitalist model. Team building and implementation of evidence-based practice is inherently easier with a defined group of clinicians. Associate providers, such as advanced practice nurses, can play a pivotal role in the multidisciplinary team to ensure that information flows across settings and that all clinicians are current on the plan of care.

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Fig 2: The Importance of Managing Transitions Across the Continuum



As providers consider approaches to align clinicians within a multidisciplinary team, one key consideration will be the balance between optimizing management of the patient within a primary care practice versus within a given specialty or service line. In fact, providers may choose to use both approaches to ensure that patients are aligned with the most appropriate care team, given a particular set of clinical conditions. For patients requiring general primary care, providers will increasingly look to some form of a medical home model to manage a group of patients. This model can also be employed for patients with chronic conditions, such as diabetes and cardiac disease. Advanced practice nurses will work closely with physicians in this model to extend the reach to a larger population of patients. They will also proactively follow up with patients to monitor clinical status and ensure compliance with the prescribed treatment, with the overall objective of keeping patients healthier and avoiding utilization of more costly or unreimbursed resources.

Within specialties and service lines, providers have the option of aligning a multidisciplinary care team around the patient, regardless of the care setting. While the overall plan of care can be driven by a physician, the day to day coordination can be accomplished by an advanced practice nurse who can round on the patient regardless of whether the patient is at home or in an inpatient or post-acute facility. The advanced practice nurse can provide the continuity across settings by ensuring that all clinicians possess a current understanding of the patient's status and the plan of care. This model also ensures that established guidelines and evidence are consistently followed regardless of the patient location. The advanced practice nurse can also act as the facilitator when multidisciplinary teams from different settings come together to discuss and agree on changes to the overall plan of care. An intersection with a more general primary care practice can be created by having the advanced practice nurses from each area work as a team for the patient population with crossover.

A culture of clinical effectiveness will reinforce the approach to care in all of these models. Technology will provide checks and balances to alert clinicians when deviations from established evidence-based practice occur. Collaboration and accountability within the multidisciplinary team will promote evaluation of different treatment options and agreement on the optimal plan of care for the patient. While clinicians will continue to have the latitude to exercise professional judgment, particularly in the absence of evidence, improved capture of outcomes data linked to cost and reimbursement data will enable the team to evaluate the effectiveness of different treatment plans.

The Road Ahead

As the realities of health care reform loom ever closer, providers must begin to close the performance gaps that exist today in most care delivery models. Regardless of the method that providers chose to employ to manage patient care across the continuum, the successful models of the future will possess several common characteristics. At the foundation, they will be based on multidisciplinary care teams that are aligned around a common set of objectives, communicate directly with each other and collaborate on priority-setting and decision-making. The teams will leverage the physician by emphasizing the inclusion of associate providers into pivotal roles that extend the team to a broader population and, in some cases, act as a coordinating figure across settings and teams. While technology will be treated as a vital enabler for standardizing the capture of clinical information, ensuring widespread and timely availability of that information, and in facilitating compliance with safety and evidence-based protocols, it will not serve as a substitute for direct interaction among members of the health care team. Providers that achieve consistently high performance in the basic competencies will command a competitive advantage that will support them in an environment of greater risk.

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CASE STUDY

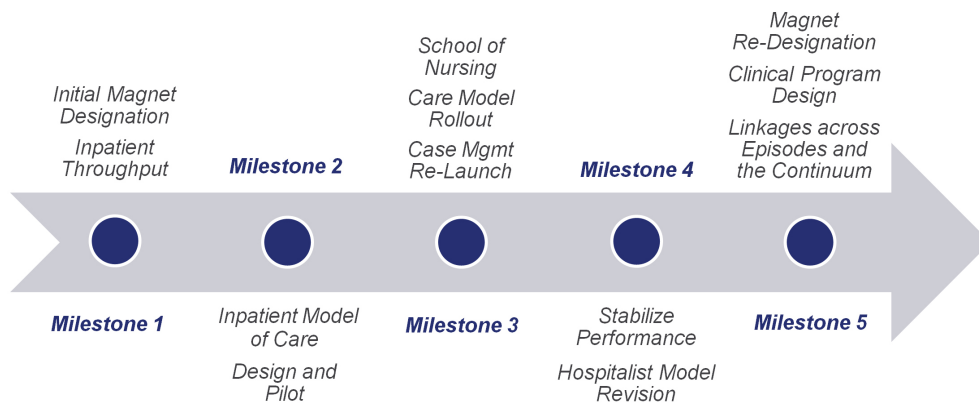
An academic medical center developed and executed against a multi-year improvement roadmap that allowed it to dramatically improve care delivery processes and outcomes (Figure 3). At the start of the journey, the organization faced chronic delays in patient access and throughput, an increasing length of stay for medicine patients, severe staffing shortages in nursing and a silo culture in which physicians, nurses and other ancillary staff collaborated by exception.

The organization embarked on an inpatient throughput initiative to solidify referral patterns with physicians by improving access to care and to the AMC's services for their patients. Subsequent to designing a centralized patient placement center and streamlining all patient access processes, the hospital initiated a joint project with the School of Medicine to improve the care delivery model. Physicians were more tightly integrated into a new multidisciplinary team structure that included a "free charge nurse" focused on patient flow and an advanced practice nurse focused on elevating the skill set of nursing staff. A daily rounding process ensured that the entire team understood the plan of care and the priorities for the day. As the organization rolled out the changes, defined periods of time were allocated to stabilize and consolidate performance gains. The modifications to the care delivery model were ultimately budget-neutral with the transition funded by the increase in revenue resulting from improvements in patient throughput.

The results of these two inpatient focused initiatives included a 25% increase in physician satisfaction, 30-50% reduction in wait time for patients admitted from the ED or directly from a physician's office, a 70% reduction in ED diversion hours, an increase in average daily census of 100 patients with the same bed base, elimination of RN agency usage, and decreases in RN vacancy rates from 50% to as low as 8% on some units. Other benefits included a change in the culture on the inpatient units to one where the next patient was sought after, as well as the development of defined career paths for staff nurses.

Finally, the organization began to develop clinical programs that further facilitate the alignment of planning and care delivery. In a new pilot program, advanced practice nurses, funded equally by the hospital and School of Medicine, round daily on patients in their clinical program, regardless of the setting, to ensure a smooth and seamless transition as patients progress and to improve communication flow among referring physicians and the campus-based teams. The advanced practice nurses bill for services under the auspices of the faculty practice. The organization continues to advance its care delivery model to improve patient care and prepare for the future environment.

Fig. 3: Care Delivery Redesign Road-Map



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