The Risks and Rewards of Value-Based Reimbursement

Robert J. Henkel, FACHE, and Patricia A. Maryland

Summary • As healthcare systems across the country shift to value-based care, they face an enormous challenge. Not only must they reimagine how they identify, engage, and manage the care of patients, they also need to determine new ways of engaging and aligning physicians and other caregivers in creating better-coordinated care across the continuum.

This article explores how healthcare systems making the transition from volume to value can maximize their reward while managing their risk. As the largest not-for-profit healthcare system in the United States and the largest Catholic healthcare system in the world, Ascension is committed to making its own transition, marked by broad-based innovation. We call this goal the Quadruple Aim: improving health outcomes, patient experiences, and provider experiences while lowering the overall cost of care.

Healthcare systems and providers have many value-based models to choose from, including pay for performance (P4P), shared savings, bundled payments, shared risk, global capitation, and provider-sponsored health plans. Analysis of these options should include an evaluation of market readiness (i.e., the ability of a health system to align with the needs of employers or commercial insurers in a given market). Healthcare systems also must be prepared to invest in resources that facilitate effective transitions and continuity of care—for example, care management. In addition, they need to recognize that as they focus on wellness, inpatient volumes will decline, requiring cost-structure adjustments and added ancillary services to compensate for this decline. Some healthcare systems are even exploring the possibility of becoming their own payer, taking on more risk and responsibility for the health of patients and populations.
Myriad experimental value-based models are emerging to address healthcare's rising costs while putting patients at the center of the healthcare experience. One such model, which showed Ascension its path forward, is MissionPoint Health Partners, our Nashville-based population health management subsidiary. A few years ago, MissionPoint determined that the costliest 5 percent of its patients were generating more than 60 percent of costs. As a result, MissionPoint began matching its highest-risk patients with health partners, who develop a care path specifically addressing patients’ unique needs.

Through these and other efforts, MissionPoint has lowered readmission rates by 4 percent, eliminated one-third of expected emergency department (ED) visits, and moved more patients from brand-name to equivalent generic drugs. Another outcome has been growth. Since 2011, MissionPoint has expanded from one state to serve six states with more than 7,900 providers and 250,000 members while managing $1.5 billion in healthcare spending. More important, MissionPoint is delivering improved person-centered care and better patient and provider experiences at a lower overall cost. In short, it is reducing risk and delivering value. The model is working.

Ascension today covers approximately 2.4 million patients through various value-based payment arrangements that represent less than 20 percent of overall revenue. By 2020, we want 75 percent of our operational revenue to stem from value-based arrangements. In this article, we outline our path to reaching that goal.

**Introduction**

We are reaching an inflection point in healthcare. As value-based reimbursement models gain a stronger foothold in healthcare, the biggest question remains: How do we manage the financial risks while continuing to deliver safe, high-quality, and effective care to those who need it? For Ascension, undertaking this transformation is critical to living out our mission, vision, values, and strategic direction, which call us to provide healthcare that works, healthcare that is safe, and healthcare that leaves no one behind for life.

In 2013, Ascension completed a strategic positioning assessment of each of our markets. From that analysis, we determined that successfully shifting from volume to value was essential to the long-term sustainability of our regional health ministries, which provide clinically integrated care. We were also encouraged to see the US Department of Health & Human Services set goals in January 2015 regarding the shift to value-based reimbursements (Centers for Medicare & Medicaid Services [CMS] 2015). We became members of its Health Care Transformation Task Force (2015), which set a member goal of having 75 percent of operational revenues in value-based payment arrangements by 2020 through the Better Care, Smarter Spending, Healthier People initiative.

Consequently, we believe the issue has morphed from **whether** to change to how and to what degree to change. In fact, according to a HealthLeaders Media (2015, 2) industry survey, 85 percent of healthcare organizations report pursuing value-based care in some capacity. According to the survey, 32 percent of respondents cited future revenue streams as a hurdle between their current state and their ability to pursue a more vigorous transition to a value-based model of care.

We detail here what we see as the challenges ahead in healthcare and the risks
associated with the transition from traditional to value-based reimbursement. We discuss our views on the models depicted in Exhibit 1 for value-based reimbursement that are most likely to succeed, and we provide a set of guiding questions that can help jump-start an organization’s move to value-based care. We also provide a case study from an Ascension subsidiary, Nashville-based MissionPoint Health Partners, to showcase a model built around a patient-first approach. Finally, in a sidebar near the end of the article, we present the points of view of several Ascension healthcare executives on the future of healthcare.

**The Challenge**

Faced with a changing environment, healthcare systems must address the possibility that unless they achieve significant gains in market share, the change to value-based reimbursement could lead to a significant net loss resulting from reimbursement reductions, fixed infrastructure costs, and declining inpatient utilization. With this in mind, systems must examine their fundamental mission and consider the possible consequences of not participating in the transition. As the largest Catholic and not-for-profit healthcare system in the United States, Ascension recognizes that despite the complexities of this dynamic market, the consequences of not acting—or not acting soon enough—could fundamentally affect the organization and the communities it serves.

Ascension currently covers approximately 2.4 million individuals through various value-based payment arrangements. These arrangements represent less than 20 percent of our overall revenue. As the healthcare landscape continues to evolve, we are beginning to position the organization for a significant shift toward a larger

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**Exhibit 1** Value-Based Spectrum of Risk and Associated Capabilities

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portion of our revenue coming in the form of value-based payment arrangements.

Over the years, population health needs have changed. Ascension has responded with a sharp focus on working as an integrated, national healing organization. Our approach has taken the form of an internal initiative we call One Ascension, whose goal is to deliver improved health outcomes with enhanced person-centered and provider experiences at a lower cost of care to those we serve. We see this as a multiphased approach—co-led with our physicians—that keeps the focus on the patient and maintains an ever-present respect for differences in the communities we serve. To achieve our One Ascension goal, we will use our resources to rapidly test various approaches in our diverse markets, at varying levels of risk, until we find the right formula. As we learn from these pilots, we will replicate best practices across our national health ministry to continue our One Ascension journey in the most efficient form possible.

Fundamental to our approach is the development of clinically integrated systems of care in each of our regions. A system of this scale requires collaboration among private-practice physicians, employed physicians, and other caregivers and health systems to develop a program of clinical initiatives that improves the quality and efficiency of care delivery. Clinically integrated systems of care are designed to collect and share data from all participating providers. This process fosters interdependence and collaboration among physicians and other clinicians that can lead to quality improvements and enhanced cost-effectiveness, as well as readily accessible health information for the people we serve. A fully developed clinically integrated system of care at Ascension includes evaluation, continuous clinical performance improvement, reduction of unnecessary services, and management and support for high-cost and high-risk patients.

As noted earlier, the challenge that Ascension and other healthcare systems face is the need to make the shift to value-based reimbursement at the right time, both for the organization and for the lives we serve. A business argument can be made for maintaining the status quo on healthcare reimbursement. However, in light of the overall mission of healthcare to serve patients in the best manner possible—and the current systems’ inability to do so—we are quickly approaching the inflection point that will require healthcare systems to make the switch despite the revenue risk involved. Moreover, for Ascension specifically, the need to shift is all the more important as we look to live our vision and mission as an organization. We are already taking steps to mitigate the business risk to continue delivering on our mission.

**Value-Based Reimbursement Options**

To fully assess the transition to value-based reimbursement, we need to review the various models and weigh the inherent risks and rewards associated with each. In any model, some degree of economic risk shifts to the provider (and the healthcare system). To manage this risk, providers must reevaluate their quality metrics, safety imperatives, utilization, and cost of services to determine if they add value to the person served. Each model requires the provider to take a holistic view of how care is being delivered across the continuum by the many disparate providers of that care. The gaps in care delivery and coordination that currently exist provide enormous opportunities to transform the delivery of care in a way that is person centered. To eliminate these gaps, we must create
value by design that is based on the patient’s needs, the population’s needs, or both.

We review here the advantages and disadvantages of each fee-for-value option, cognizant of the fact that most healthcare systems will experiment with a combination of these models depending on their specific markets.

**Pay for Performance (P4P)**
- **Overview:** As implied, P4P works by establishing, measuring, and reporting clinical quality benchmarks. This approach rewards providers for reaching clinical quality aims.
- **Risks:** Some would argue that the P4P model still rewards volume rather than value because providers are “rewarded” without necessarily reducing services. An additional concern is that the amount of reimbursement may decrease in comparison with the reporting required.
- **Rewards:** P4P may be the best option for smaller practices that seek to align provider payment with value to avoid large capital expenditures associated with the development of robust information technology (IT) capabilities and clinical integration.

**Shared Savings**
- **Overview:** The Medicare shared-savings model rewards providers who reduce total healthcare spending beyond an agreed-upon level determined by the payer. This approach presents an upside risk of losing additional revenue but also a potential reward for increasing quality and cutting costs.
- **Risks:** Like many value-based models, an up-front cost is associated with developing the health IT and quality measurement infrastructure needed to reduce healthcare costs. Despite the fundamental benefit of having improved processes or technologies, the investment may not be worth the shared-savings reimbursement in the short term. This model also assumes that providers are overspending. It could penalize those who have already found ways to cut healthcare spending while providing high-quality care. They may find it difficult to cut costs enough to earn sufficient rewards. Furthermore, primary care services, such as those provided by nurse care managers and consultations with other physicians, are not necessarily covered in this model. Some question the model’s sustainability after initial savings have been achieved and shared.
- **Rewards:** Providers receive a bonus when they reduce healthcare costs but do not incur a penalty if they fall short of the goal. The program also incentivizes provider quality performance by reimbursing at a higher rate of shared savings if certain metrics are met. The shared savings model aligns with the CMS Physician Quality Reporting System (PQRS) and other quality initiatives and, as a result, qualifies for PQRS incentive payment as well (CMS 2014). As Bailit and Hughes (2011, 4) point out, “shared-savings arrangements commonly remove costs related to patients with very high costs during the measurement period, which is typically 12 months.”

**Bundled Payments**
- **Overview:** Bundled payments are much like fixed-price contracts through which healthcare providers are provided a budget to cover the estimated costs associated with all of the care needed by a patient for a given condition or procedure—also called an episode of
The shared-risk arrangement motivates all stakeholders to work together to reduce cost.

Care. Performance incentives related to clinical quality, patient experience, and cost efficiency are also part of this model (Rosenthal 2008).

- **Risks**: The largest risk posed by this model occurs when the costs associated with an episode of care or a condition exceed the negotiated cost of services. High-risk cost outliers in particular can negatively affect reimbursement. This model also is reminiscent of fee-for-service insofar as the more episodes of care there are, the greater the potential for payment, which continues to incentivize procedures (volume) rather than value. However, this is kept in check by more comprehensive-care payment systems in which providers also benefit from the savings achieved by preventing unnecessary episodes of care.

- **Rewards**: In this model, providers are automatically rewarded for less costly episodes of care. This model streamlines payer accounting because payers know up front how much they will spend versus waiting to see whether any savings will be achieved. Payers also spend less per procedure. In addition, there may be an added incentive to prevent unnecessary procedures. Last, this type of payment system gives the provider flexibility to determine which services are offered to achieve the desired outcome.

Under a CMS bundled-payment model currently being piloted at a handful of hospitals, a single discounted payment is provided to the hospitals and physicians for an episode of care, such as a surgical procedure or an illness in a diagnosis-related group. In turn, the hospitals may pay physicians up to 125 percent of Medicare's fee-for-service rates and share up to 50 percent of the savings with Medicare beneficiaries. For the CMS pilot, hospitals must be accepted into the program, have the ability to demonstrate superior quality, and successfully align with physicians to lower costs and improve efficiency (Valence Health 2013).

**Shared Risk**

- **Overview**: In a shared-risk model, payers and providers determine a budget, and providers receive performance-based incentives when cost savings are realized; however, they cover a portion of the cost when savings targets are not achieved.

- **Risks**: This model clearly poses greater risks in that providers are liable for a portion of the costs of care if they exceed the targeted costs of care. Shifting more of the financial burden to providers creates an ongoing need for infrastructure and IT support, which means an additional up-front investment. This model also requires a new level of spending and performance monitoring to ensure that quality of care is not stifled. Another concern involves the outliers, those patients and conditions that prove to be too much of a risk for providers. (To avoid taking on more risk than desired, providers can partner with a third party that offers stop-loss insurance or enter into a risk-corridor arrangement with the payer.)

- **Rewards**: The shared-risk arrangement motivates all stakeholders to work together to reduce cost. The payer no longer bears the entire financial responsibility, and the provider remains vital in the market by improving care and receiving powerful incentives.
Global Capitation

- **Overview:** Capitation models are based on a payment-per-person plan in which physicians accept members for a certain set price (without taking the number of visits into consideration). Provider payment is based on the costs of providing a range of predefined services to a certain number of patients in the plan over a specified period. Given its history in the 1990s, when early models tended to restrict rather than promote care, capitation has a negative reputation. However, today’s sophisticated IT, matched with more accurate risk-adjustment capabilities, makes global capitation more attractive than it has been in the past.

- **Risks:** By taking on members and assuming full risk for the volume of visits and costs of services rendered, providers significantly increase their financial exposure. They also assume a significant actuarial risk in a global capitation model.

- **Rewards:** This model incentivizes a provider to keep members as healthy as possible through preventive care. Through advancements in technology, providers and payers should be able to obtain and understand patient enrollment and utilization information more readily, leading to a more successful model.

Provider-Sponsored Health Plans

- **Overview:** In provider-sponsored health plans (PSHPs), providers assume 100 percent of the risk by directly collecting insurance premiums from members and providing care.

- **Risks:** Healthcare systems in this model have full power to decide how patients are cared for; however, the cost of that power is significant. In addition to start-up expenses (specifically, the cost of insurance), the possibility exists of costly lessons learned along the way. Providers are accepting actuarial risk and the functions of an insurance company. This model can also falter if a provider fails to attract a sufficient number of members willing to move from their current paradigm to a PSHP to successfully spread the risk across a large population.

- **Rewards:** Beyond the potential financial rewards connected to such a model (which would increase only as reimbursement amounts increase), a PSHP may garner increased market penetration and control over population health management, which may prove advantageous to health systems and providers in the long term.

Evaluating Value-Based Reimbursement Models

Making the choice to move from a traditional reimbursement model to a value-based model requires tremendous care and planning given the profound and transformative effect it will have on an organization. The following considerations may help inform decisions and scale readiness to begin a transition.

**Market**

How an organization responds will depend on its capabilities and what its commercial insurance market, employer market, or both are looking for. Is your market ready for narrow networks? The key is to match your approach to the current demands of the specific commercial insurance and employer markets—and, importantly, to the future direction of the market. Lagging the market could result in a loss of share; getting ahead of the market can result in reduced fee-for-service reimbursement with little financial gain. Also, if you are the dominant provider in
Alignment
Ascension’s integrated healing organization ensures alignment with our mission to transform healthcare systems through compassionate, personalized care. As primary care physicians (PCPs) assume a greater role in care coordination under the various value-based reimbursement models, physician involvement is critical to any successful value-based reimbursement activity. What is your physician alignment strategy? Specialist involvement is also integral to the success of any value-based model. Another important consideration is having advanced-practice nurses in interdisciplinary practice with physicians to support prevention and disease management. Nurses often can provide care at lower cost with high levels of positive patient experience and engagement. For most systems, a multifaceted physician alignment strategy is a necessary ingredient for success.

Infrastructure
Up-front infrastructure costs associated with a shift to a value-based reimbursement model are significant. Most systems that undertake this type of transformation experience a three-year learning curve. The typical health system will invest millions of dollars to develop the necessary health IT and quality measurement infrastructure during this period. Therefore, it is imperative to examine and prepare the care management substructure for the transition. Health systems approaching this phase should consider these questions:

- How have you coordinated your care managers across the continuum?
- Have you identified your continuum partners?
- Do you know what an episode of illness costs for a certain disease state over the course of 60 days? 90 days? (Have you included the cost of additional post-acute care?)
- Do you make care readily available outside of the hospital setting? Is it the lowest-cost setting? Is it convenient?
- Have you brought behavioral health capabilities to the table?
- Do you have telemedicine capabilities?
- Can your providers identify health needs at the population level and then take that information down to the individual?
- What is the connectivity between the physician’s office and ambulatory services?
- Have you met meaningful use criteria?
- How do your PCPs know where their patients are in the care continuum?
- Does the ED notify the PCP when a patient has been in the ED?
- How do you plan to monitor providers regarding generic versus brand-name prescriptions, urgent care versus ED utilization, use of high-end imaging, and inpatient utilization?
- What are you doing to manage the care of chronically ill patients?
- Do you have predictive modeling tools to identify those who will become chronically ill absent a timely intervention?
- Where are you in terms of palliative care?
- Do you provide medication therapy management services?

Finances and Patient Volume
Health systems also need to adjust their delivery system capacity and focus. Clearly,
movement toward a focus on wellness with a shift from inpatient to outpatient activities will cause a decline in hospital admissions. Some systems that have aggressively pushed the shift to value-based reimbursement models in their marketplace were surprised by how quickly utilization shifted with an almost immediate impact on profitability. To ensure a smooth transition, consider the following:

- **Have you estimated the impact on your inpatient volumes?** Ascension is currently estimating the impact of the shifting environment on our inpatient facilities. This analysis is vital as health systems adjust staffing levels and facility plans to align with the new environment.
- **Have you adjusted your cost structure?** The new healthcare environment will not be as profitable for delivery systems. We will have to continue to focus on overall productivity and economies of scale.
- **Are you prepared to make the necessary investments in ambulatory care?** A careful and strategic approach to investment is required. Organizations may not need to invest in high-end imaging but rather in systems that improve access and convenience (e.g., retail clinics). Do you plan to partner with urgent care clinics and retail clinics? Are you meeting the needs of today’s convenience-focused consumer—for example, by making physicians available after regular office hours? Do you have the technology to link with today’s consumer?
- **What is your post-acute care strategy?** Many leaders at Ascension have noted that when looking at their historical costs for an episode of illness, the largest variations were often in the post-acute care environment. One of our hospitals has developed close affiliation relationships with post-acute care providers in its area that involve use of closely monitored performance metrics designed to succeed in a value-based reimbursement environment.

### Payer Considerations

Payers should ask themselves several questions:

- Will you develop your own insurance capabilities with the understanding that doing so may cost $10–$20 million?
- Do you plan to partner closely with one payer or have a multiple-payer strategy? Your approach will clearly depend on the local market dynamics.
- What is your insurance exchange strategy? What about the private insurance exchanges—a new dynamic that will be a significant market force in the years to come?

### Value-Based Reimbursement in Action

Ascension already participates in a variety of payment models, including 14 active Medicare shared-savings programs, three ministry markets participating in Medicare bundled-payment programs, six wholly or partially owned health plans, multiple commercial accountable care organizations (ACOs), and four Programs of All-Inclusive Care for the Elderly (PACE). We also manage 179,000 lives through our SmartHealth program for our associates and their dependents. Ascension subsidiary MissionPoint Health Partners developed one such model. Long before the Affordable Care Act and shared savings became household terms, MissionPoint CEO Jason Dinger and his team asked patients, health insurance companies, physicians, specialists,
and hospital CEOs—virtually everyone involved in healthcare delivery—one question: What do you think is wrong with healthcare today? Responses varied widely:

- Physicians want to get back to what they do best, using evidence-based interventions as their guide, and they also want help managing cash flow.
- Patients want more access to and availability of care.
- Payers want a way to manage costs while ensuring quality.

MissionPoint determined that directly managing just 5 percent of its costliest patients would address more than 60 percent of its overall healthcare costs.

The challenge became designing a system to satisfy all of these needs while keeping person-centered care at the forefront. What MissionPoint began in 2011 at Saint Thomas Health (an Ascension ministry) as an answer to these pressing healthcare concerns now serves six states with more than 7,900 providers, cares for 250,000 members and counting, and manages $1.5 billion in healthcare spending. Exhibit 2 depicts the basics of how MissionPoint works and the results it has achieved.

Elevated Care to Match Elevated Risk
MissionPoint determined early on that directly managing just 5 percent of its costliest patients would address more than 60 percent of its overall healthcare costs. Therefore, MissionPoint matches each plan member who exhibits a high risk with a health partner who develops a care path that specifically addresses the member’s unique care needs. But health partners add much more than care coordination to the equation: One of their primary roles is to gather as much information (both clinical and nonclinical longitudinal data) about the people they serve rather than just information about the conditions that made these patients high risk. Collecting these data has a two-pronged effect: (1) It aids in providing the best standard of care to members in greatest need (in direct alignment with Ascension’s mission and values), and (2) it helps inform MissionPoint of the best-practice interventions that will continue to keep members as healthy as possible.

Asking the Right Questions
MissionPoint prides itself on the ability to discover nonclinical data and derive conclusions from these data, with the goal of preventing potentially hazardous situations.

The process begins with asking the right questions. For example, by asking seemingly odd questions such as if members use a step stool to get into bed or if patients with asthma have purchased the plastic spacer for their inhaler, MissionPoint has helped members avoid costly health incidents. By connecting the dots with the data health partners provide, MissionPoint knows that members who use a step stool to climb into bed are more likely to suffer a fall than those who do not. Members with asthma who purchase the costly plastic spacer for their inhaler, MissionPoint has helped members avoid costly health incidents. By connecting the dots with the data health partners provide, MissionPoint knows that members who use a step stool to climb into bed are more likely to suffer a fall than those who do not. Members with asthma who purchase the plastic spacer for their inhaler, MissionPoint has helped members avoid costly health incidents. By connecting the dots with the data health partners provide, MissionPoint knows that members who use a step stool to climb into bed are more likely to suffer a fall than those who do not. Members with asthma who purchase the plastic spacer for their inhaler, MissionPoint helps inform MissionPoint of the best-practice interventions that will continue to keep members as healthy as possible.

MissionPoint CEO Jason Dinger says, “We’ve only uncovered the tip of the iceberg with assessing nonclinical data. MissionPoint works hard at being open to the things that affect people’s healthcare experience. With our team engaged at the patient level, we are getting much more real-time feedback on the interventions we have put in place.”
Forward Thinking

“Health 3.0” requires forward thinking, and MissionPoint remains on the cutting edge of that change. Dinger and his team members see healthcare evolving on three primary fronts:

1. Healthcare as an Internet of Things:
   Although not a new concept, the Internet of Things in healthcare is still in its infancy. Dinger views this convergence as a norm of the future in which smart devices such as phones or even refrigerators can report and react to certain results, such as daily functioning levels, fetal monitoring results, electrocardiogram findings, and blood glucose data that currently require interaction with a healthcare provider. Matching this
smart technology with healthcare might be something like automatically checking in on a member when his thermostat is higher than 80 degrees or making a telephone call to a member who hasn’t opened her refrigerator by 10 a.m.

2. **Video volume:** MissionPoint also envisions a broader proliferation of video, such as real-time video chats with clinical service centers, in the not-too-distant future. This idea has already become a reality at Ascension’s Saint Thomas Health, where a high-definition video conferencing system offers virtual care at a distance. This system has significantly reduced patient and physician travel time while increasing availability of timely consultations.

3. **Domestic direction:** Working its way out of the hospital and into the household, MissionPoint aims to focus on gaining a better understanding of the environmental factors that may contribute to the poor diet, infrequent exercise, or poor air quality that brings someone to the hospital in the first place. Once these factors are identified, interventions can be deployed in the household setting.

**Results**

Since 2011, MissionPoint has lowered readmission rates by 4 percent; eliminated one-third of expected visits to the ED; and moved more patients from brand-name to equivalent generic drugs—all of which have had a profound effect on healthcare spending while improving the health of its members.

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**Ascension Experts Weigh In**

We asked Ascension leaders to comment on how they see a transformed healthcare system five to ten years from now.

**David B. Pryor, MD, executive vice president and chief clinical officer, Ascension**

I see a model in which patients are supported beyond the service provided to reduce future interventions and complications. Ideally, we would go even further, by supporting care for individuals who do not yet need interventions, thus preventing or delaying the onset of chronic diseases and managing overall healthcare and cost of care beyond a single-year horizon. Instead of beginning with a business model and trying to adapt care models, perhaps we should start with the right care models and adapt our business models to support that care. The right care delivered in the right way and available to all is the goal that should be embraced by everyone in healthcare.

**Ann Hendrich, RN, PhD, FAAN, senior vice president, chief quality/safety and nursing officer, Ascension Health**

In the short term, healthcare systems will be looking for niche partners to resolve the current challenges. Certain aspects of care, including prevention and disease management, will be delivered by providers who are not necessarily physicians. A multidisciplinary team approach will be a fundamental attribute of care models going forward, with the consumer as the ultimate decision maker. This does not mean simply putting consumers on various groups or committees, but rather making them key decision makers who help design approaches and care models that meet their needs. Mobile, accessible, and convenient will be characteristics of the new healthcare system within ten years.

(continued)
Virtual care also will prevail, with technologies and self-management apps and devices that will enable consumers to self-manage larger portions of their health. Finally, the hospital will be small, but care will be intense and reserved for critically ill patients.

Samson Jesudass, MD, chief clinical officer for the Ascension Texas Ministry Market

I envision an environment in which a patient is seen as a whole person instead of merely as a patient. In the current healthcare system, one must be sick to be helped. We want to make the transition from sick care to healthcare. A person is a patient when he or she is sick, which, for some, may equate to only five or ten minutes in an entire year. We want to manage the needs of the whole person to keep him or her healthy.

Ziad Haydar, MD, senior vice president and chief clinical officer, Ascension Health

I envision a system in which revenue comes from populations of employers and from health insurance companies. Transformed care puts the nurses and physicians in touch with their vocation of healing and restores the joy of practicing their profession. A transformed system is accessible, convenient, and on a par with the reliability and service expectations of other service industries in the twenty-first century.

Michael H. Schatzlein, MD, senior vice president, Ascension Health/group ministry operating executive president and CEO of Ascension’s St. Vincent’s HealthCare, Jacksonville, Florida

I see people who are happier and healthier. I envision a system in which we bring back the joy of practicing medicine to physicians who have more time to spend with patients. Ascension is leading in this arena, and I hope others will follow. Just as we led with safety in hospitals, hopefully we can bring the rest of the US healthcare system with us through value-based reimbursements. Doing so takes courage, strength, and knowledge.

Peter M. Leibold, chief advocacy officer, Ascension Health

In an ideal world—hopefully within ten years—groups of clinically integrated healthcare providers will be evaluated and incentivized on the basis of how healthy they keep their patients. I see a system in which more management and monitoring take place to prevent acute events, which will result in happier, healthier people. I see clinically integrated providers whose electronic health records talk to one another, so that as people move through the health system, information can flow seamlessly between providers. From the standpoint of consumers, people will not feel alone because they will no longer have to manage their own healthcare. I see less pain and inconvenience and more touches by less-expensive providers so, in the end, people are happier with their health status.

Eric S. Engler, senior vice president and chief strategy officer, Ascension Health

I see Ascension leading the way with a transformed healthcare system committed to the health and well-being of communities—a system that responds to the needs of individuals throughout their life cycle. More than five years ago, we committed to the concept of person-centered care, and our 149,000 associates and caregivers continue to be inspired each day to deliver care that is truly person centered, with special attention to those who are poor and vulnerable.
Conclusion

With today’s fragmented delivery of care, the need is increasing for well-coordinated and integrated systems focused on the needs of the patient, operating under a value-based model. This approach represents a fundamental shift in the way healthcare is delivered in the United States. It is not an easy or a quick fix. The shift to a value-based care system will require that providers reconsider how they identify, engage, and manage patients, as well as how they engage and align physicians and other caregivers in creating new ways to coordinate care across different sites. The challenge before us today is monumental, especially as payment systems continue to incentivize providers for volume over value. Because of the enormity of the challenge, the volume-to-value transformation will require the involvement of federal and state governments and key commercial payers to align payment systems under the Quadruple Aim: improved health outcomes, enhanced patient experiences, and enhanced provider experiences at a lower overall cost of care.

References


