QUALITY AS A FUNCTION OF SYSTEMS-BASED PRACTICE

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As our healthcare systems evolve, our concepts of quality increasingly remind me of the story of the blind men describing an elephant. Is it a snake? A wall? A rope? HEDIS measures? CAHPS? Readmission rates? IQR? MSSP ACO?

And which perspective -- patients? payers? providers? -- should determine the benchmarks that constitute 'value'?

While a universal perspective may be accounted for under the IHI "Triple Aim" model, in our current systems of care, payers and health plan sponsors are the drivers of what constitutes 'value'. Today, this is largely based on cost savings in the context of a set of quality measures and patient satisfaction scores. The quality measures all have some evidence-base for patient-centered 'value' – both in terms of actuarial value across a population (e.g., reducing health risks of obesity) and individual benefits (reducing preventable inpatient experiences).

With this model as a context, the question for providers becomes: should quality measures drive clinical operations or are they simply indicators of practice-level trends towards best practice?

Visiting Physicians Association (VPA) is a 14-state practice network that exclusively provides 'home-based primary care' to patients, largely defined by Medicare rules for home-bound status, but also in collaboration with select managed care organizations for select complex/fragile patients. VPA has significant emerging experience with value-based care delivery, having participated in a Pioneer ACO and now, in collaboration with its management service organization US Medical Management, supporting a 20,000+ patient multi-state Medicare Shared Savings ACO. VPA practices were also significant participants in the national Center for Medicare and Medicaid Services Independence at Home I(IAH) Demonstration. In the first year of IAH, VPA was able to demonstrate its high quality performance by dramatically reducing hospitalizations for ambulatory sensitive conditions, 30-day readmission rates and emergency department utilization, while meeting the highest standards for patient satisfaction and engagement.

However, contrary to common practice, VPA did not manage to measures; we did not share quality or utilization data with our providers during the first year. VPA takes a systems-based approach to clinical operations and care delivery, improving quality and outcomes by revitalizing the experience of care for both patients and providers. This system is designed to support the organic emergence of best practices in patient care. Our approach is based on five core principles:

First, a commitment to continuity. A recent internal case-control study confirmed that when VPA provides 75% or more of primary care services, we make a dramatic difference in a patient's quality. The majority of our patients have 5+ chronic conditions and 7+ medications, most have more; as such, we don't wait for them to call us. We connect with almost every patient, in person, at least once a month. We encourage connection by providing, and encouraging, access to our providers through our Patient Care Coordination Center 24 hours a day, 7 days a week.

Second, what we call "professional intimacy". We get deeply, personally involved with our patients, their families, their caregivers in an ongoing and consistent manner. We support limiting provider census in order to encourage longer visit time. We worry, and share the work of worry with families; in most cases, we consider ourselves an extension of their family; this powers our capacity to manage ambulatory sensitive conditions and post-acute care.

Third, a formal collaboration framework. VPA care is based in core 3-role clinical team consisting of a Provider (Physician or nurse-practitioner), a Medical Assistant (MA) and an unseen but always connected "Patient Care Coordinator" (PCC), who serves as a communications hub. All members of the team work from the same clinical data network. We've not just defined the roles and responsibilities of all the members of our team but also choreographed and rehearsed their interaction design -- both within the team and with the broader continuum of care.

Fourth, we invest in the continuum of care: lab, radiology/diagnostics, home health, and hospice – and even podiatry -- are all fully integrated in our model in order to meet our standards for responsiveness and accountability. ROI is calculated across the full continuum, taking the pressure off any individual service for financial performance.

Fifth, we practice complex primary care. Most of our patients are so fragile or complex that by the time symptoms develop they are at extremely high risk for a downward spiral. VPA clinical teams use advanced clinical decision support tools based on our own protocols to anticipate problems, monitor clinical and laboratory findings and track a patient's health in order to get in front of any emerging issue or change in their status. Many of our patients have an 'allowable admission' hanging over their heads all the time; we just don't allow it. Our providers are trained and supported to fully manage their patient's complexity and extend their scope of practice to the top of their training and licensure.

Approaches to quality improvement have largely been driven by analytics and reporting and continuous improvement models. Our experience with home-based complex primary care has exposed a set of principles which can be technologically enabled, but are driven more by systems-based practice. While home-based primary care may have unique features when compared to traditional ambulatory care, there are learnings from our experience that are transferable across the spectrum of care delivery.