Community Care Alliance

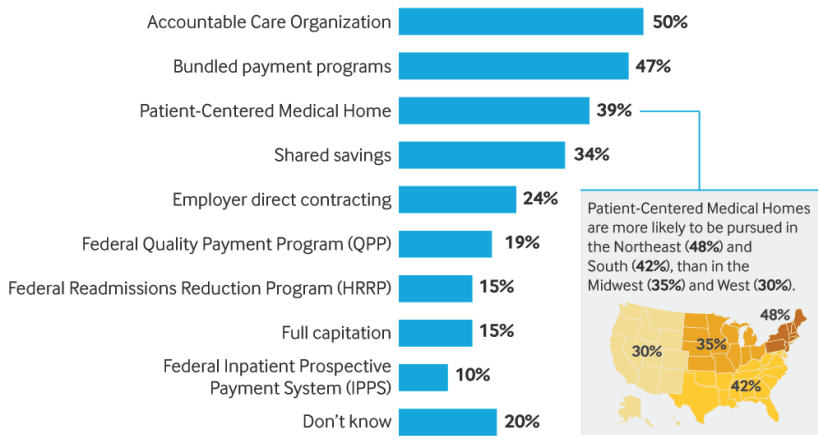
Connie's Clips

And the Survey Says…

Value-based care makes a bold promise: to reduce costs, improve care, and boost patient experience, all while keeping practitioners happy. Yes, these goals seem overwhelming to achieve, but as the healthcare system continues to seek value and move away from the fee-for-service payment model, the risks of not embracing value-based care models are becoming more and more real.

What are your strategies for engaging in value-based reimbursement models? Do you know which models are considered value-based in your organization? Consider the results of a survey conducted in July 2018. Members of the NEJM Catalyst Insights Council – comprised of healthcare executives, clinical leaders, and clinicians – were surveyed about transitioning payment models from fee-for-service to value-based care. Completed surveys from 552 respondents are included in the analysis.

Which value-based care models is your organization actively pursuing?



Base: 552 (multiple responses)
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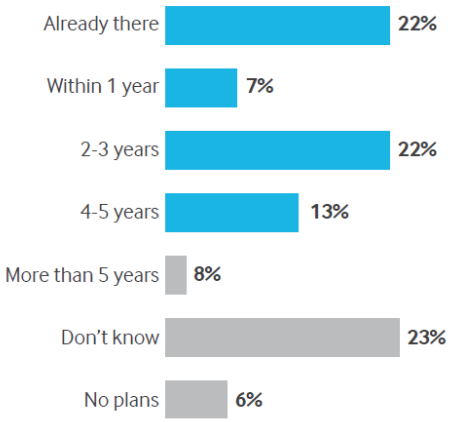
Half of survey respondents say their organizations participate in Accountable Care Organizations (ACOs). Bundled payment programs follow closely among value-based care models that health care organizations are actively pursuing. Responses for Patient-Centered Medical Homes and shared savings approaches form a second tier. Shared savings models are more prevalent in the Midwest (39%), Northeast (37%), and South (36%) than the West (24%). A number of respondents cite Medicaid Delivery System Reform Incentive Payment programs (DSRIP) under the "Other" category.

What is the status of your organization moving toward value-based care?



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Nearly one-quarter of respondents say that their organization has already achieved value-based care, and another 29% say they will get there within the next three years. A greater share of executives (27%) and clinical leaders (25%) than clinicians (17%) say their organizations have made the transition to providing value-based care. Aggregating the data reveals that just over half of respondents expect their organizations to be value-based in three years. In a written comment, a clinical leader in the South says the key to accelerating the adoption of value-based care is "Data agreed on by payers, researchers, and clinicians that actually saves money – including hidden costs – and improves health of Americans and our health care system over the long haul." But another clinical leader in the same region cautions, "We are a long way off from being able to track metrics as well, at least in my state."

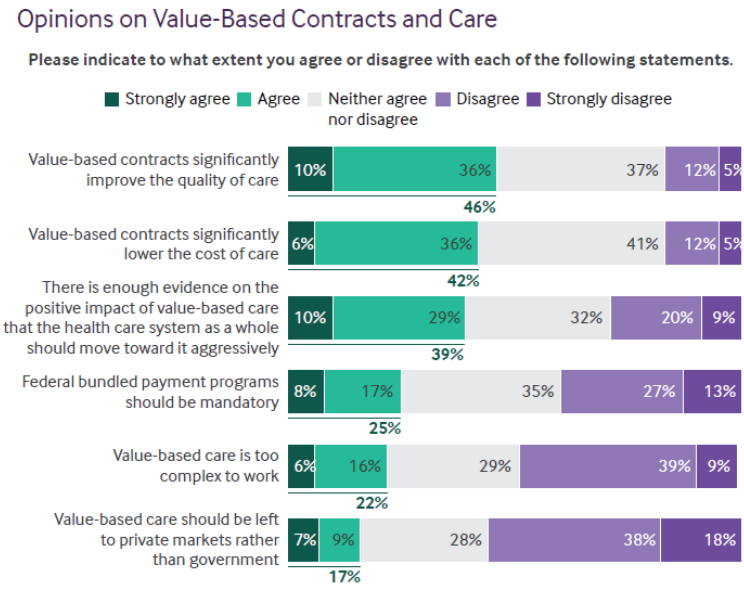
Nearly a quarter of respondents don't know their organization's status. This suggests there may be a need for greater transparency from leadership regarding value-based activities. When asked about the status of their organization moving toward value-based care, more than a quarter of the respondents said that they are or will be involved within a year.

There is widespread agreement among Insights Council members about the benefits of value-based care. Nearly half say they either agree or strongly agree that value-based contracts significantly improve the quality of care, and 42% say they agree or strongly agree that value-based contracts significantly lower the cost of care. On the other hand, more than a third of respondents are undecided on the impact that value-based contracts have on the quality and cost of care. This suggests that, for many providers, the jury is still out on the benefits of value-based care.

Executives on the whole are more bullish than clinicians about value-based care: whether it significantly improves the quality of care (executives 55%, clinicians 38%) or lowers the cost of care (executives 50%, clinicians 36%); and whether there is enough evidence about the positive impact of value-based care that the health system as a whole should move toward it aggressively (executives 55%, clinicians 38%).

A plurality of respondents do not believe that value-based care should be left to private markets rather than the government (disagree 56%, agree 17%); or that value-based care is too complex to work (disagree 48%, agree 22%).

More than 85% of survey respondents say a range of metrics for measuring value-based care are important, very important, or extremely important. Outcome measures are rated extremely important by nearly two-thirds. A greater share of executives (42%) and clinical leaders (38%) than clinicians (31%) say cost measures are extremely important.



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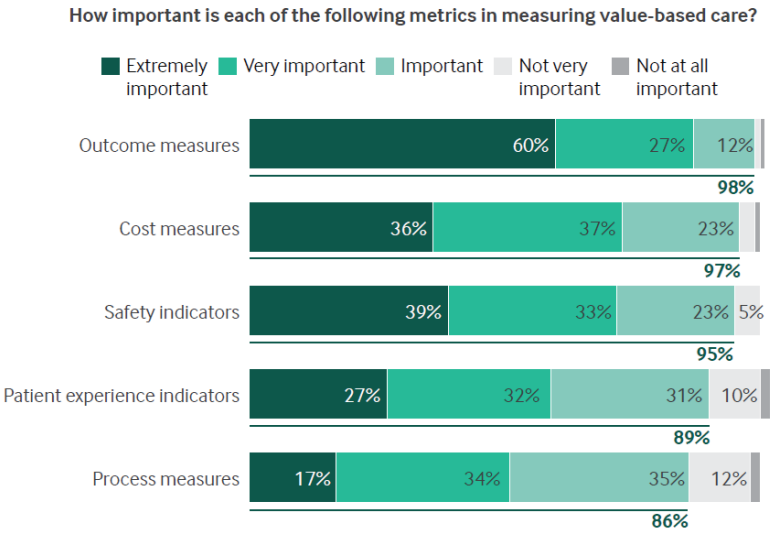

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The survey also identifies the leading barriers to implementing value-based reimbursement models. Infrastructure requirements, including information technology (indicated by 42% of respondents), and changing regulation/policy (34%) are the top two. Additional barriers include problems related to management – administrative details (33%) and concerns about sustainability (28%).

To me, this survey suggests that value-based reimbursement is a real solution to our healthcare crisis. Value-based reimbursement is improving care and lowering cost. I believe that Western Healthcare Alliance made the right choice to create the Community Care Alliance (CCA), removing the leading barrier to implementing value-based reimbursement models: infrastructure requirements. The CCA is your centralized, cost efficient support infrastructure that provides population health solutions and value-based contracts with various payers. And now, CCA is expanding to payers beyond Medicare through the newly formed CCA Clinically Integrated Network (CIN). The CCA CIN is purposely designed to allow participants to opt-in to value-based agreements with payers that make sense for the participant. What's stopping you from joining?

SIGN UP TODAY!

Value-based contracts launch July 1st! Reach out to learn more!

Contact me, Connie Mack, Executive Director for the CCA today!

communitycarealliance.com