



Examining Health Care

Demystifying Global Payments - Part 4 Investing in More Effective and Efficient Care

In part three of this series, we pointed out that global payments combined with performance incentives can stimulate a transformation in medical practice by enabling care that is more effective and efficient. Simply put, effective means providing services based on the best available scientific knowledge to all who could benefit; efficient means avoiding waste of resources. But how does a provider group know if it is effective, and how does it identify and drive out waste?

The first step is to develop and share data and information. Using insurance claims and their own health information technology, provider groups can analyze their medical utilization and expense data to pinpoint patterns of care that are not consistent with the best evidence, and to identify unexplained variations among practice sites or individual clinicians that might indicate inappropriate or unnecessary procedures, tests or medications. Similarly, providers should know exactly how they stand in relation to evidence-based standards that are used to determine quality performance standards. Openly sharing and discussing these kinds of data within practices creates momentum for individual and collective improvements.

Investing in Improved Patient Care

With well-designed global payments, provider organizations that achieve increased efficiency and effectiveness receive financial benefits in the form of budget savings and performance bonuses. This, in turn, enables additional investments in clinical improvements and programs that may not be reimbursable under fee-for-service. Here are a few examples, based on our own experience:

Coordinating ambulatory and inpatient care: Nurses and clinical social workers help coordinate the care of patients in a variety of non-hospital settings, including home care, community programs, skilled nursing, rehabilitation, and long-term care. Similarly, hospital-based care managers develop discharge plans and coordinate care with practice-based clinicians to help reduce the chance of readmission by helping patients make safe transitions from hospital to home.

Outreach for wellness, prevention, and chronic disease management: Groups develop health education and promotion programs and

outreach to patients to ensure that they receive immunizations, colonoscopies, mammograms, and other screenings when appropriate. They also use claims data and patient registries to identify patients with chronic conditions who may have gaps in recommended tests or in the control of their conditions. Clinicians can then reach out to the patients to encourage them to get needed care. At Atrius Health, our disease management nurses work with many patients who have multiple chronic conditions, both during office visits and by phone, to educate them about their diseases and medications and to help them reduce their risk factors through self-management. We are also piloting programs with health coaches to work with motivated well patients to improve their risk profile by encouraging exercise, weight loss, and smoking cessation.

Improving the safety and effectiveness of drug prescribing: Groups can facilitate the adoption of e-prescribing, and also develop or contract for pharmacy resources and programs to analyze drug utilization trends; provide clinicians with data on their own prescribing patterns; keep clinicians informed of withdrawals or recalls of drugs; provide information and guidelines on new drugs; and identify patients with high drug costs to flag possible safety issues, and when appropriate, recommend alternative prescribing strategies.

Enhancing access to care and reducing emergency room use: In addition to offering extended evening and weekend office hours, groups can arrange for clinical telecommunication services to help with the triage of patients after hours. Depending on the severity of the problems, specially trained clinicians may give patients medical advice, refer them to an emergency room, or direct them to see their physician as soon as possible the next day. Clinician access to patient electronic medical records on a 24 X 7 basis ensures continuity and coordination of patient care.

Helping the frail elderly return home after hospitalization: Elderly patients who have been hospitalized benefit from home-based programs designed to prevent avoidable readmissions. For instance, at-risk patients can receive an assessment within a few days of their hospital discharge, as well as coordinated follow-up care from visiting nurses, social workers and other caregivers, and a regular review of their health status and living situation.

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NEXT ISSUE

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