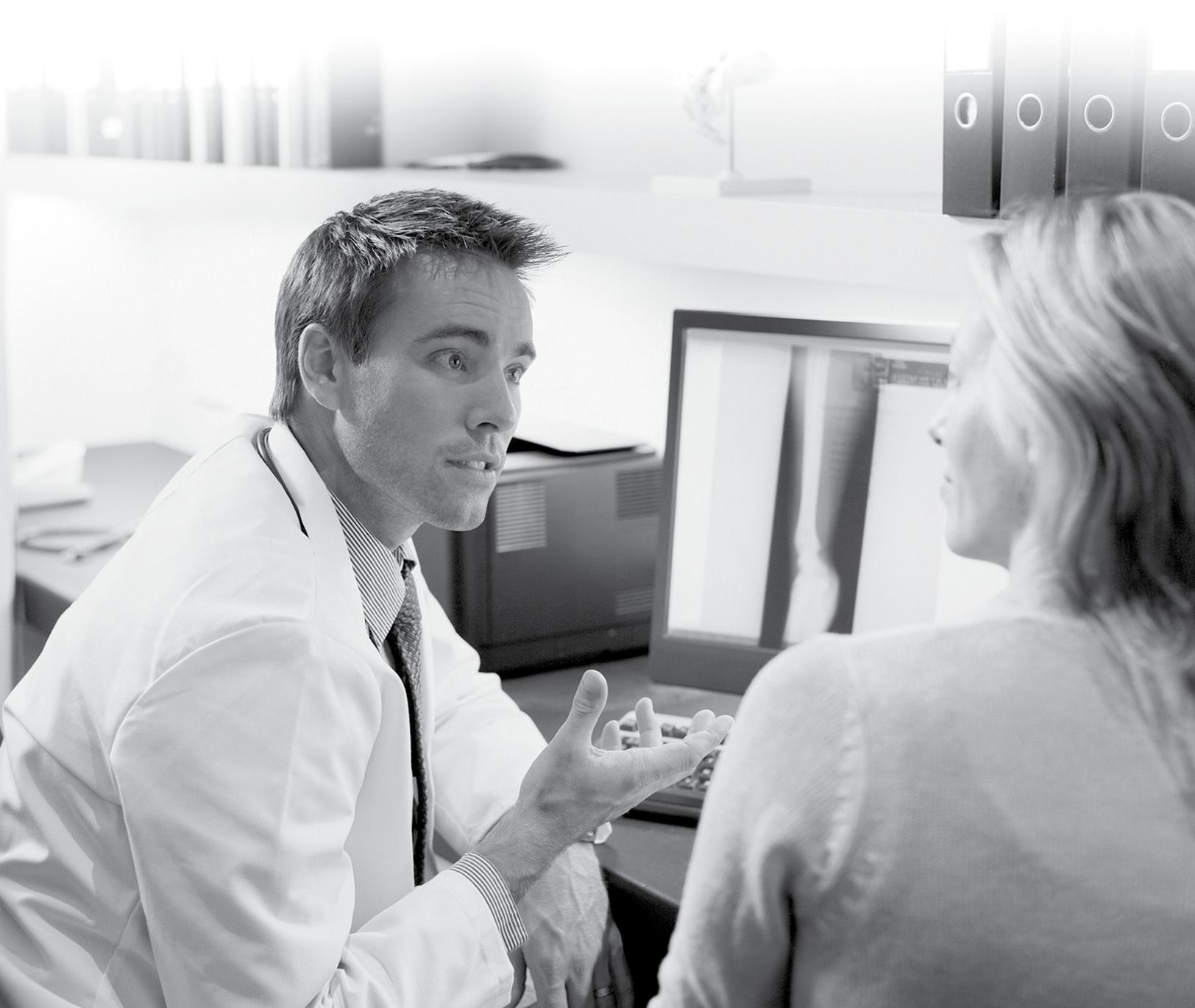


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DELIVERING ON THE PROMISE OF HEALTHIER POPULATIONS:

*How the Use of Evidence-Based Guidelines, Duration Tables, and Analytics
Drive Value-Based Success for Providers, Employers, Patients and Payers*



"ACOs are an attractive model for employers supporting a healthier workforce by extending the culture of wellness from work to the home for their employees and their families." ³

INTRODUCTION

The sweeping changes to the U.S. healthcare system ushered in by the Affordable Care Act (ACA) continue to unfold. Fundamentally, it's driving a shift from fee-for-service to value-based care models, which in turn results in new organizational strategies and consolidation. According to Insurance Thought Leadership, "In 2015, there was more than \$700 billion of consolidation in the healthcare marketplace. This is driven, in part, by the ACA, because scale and size assist providers with efficiency, purchasing power and the need to provide a continuum of care."¹ As a result, collaborative, risk-sharing care arrangements, such as Accountable Care Organizations (ACOs) are gaining momentum.

Because nearly half² of the population receives employer-sponsored health coverage, this shift is at the forefront of employers' minds. Although traditional healthcare payment models have centered on the employer-payer relationship, that model is changing. Now providers themselves are assuming risk, and, in an increasing number of instances, contracting directly with employers.

At the same time, employers are taking a more holistic view. Beyond offering health benefits to their employees to handle illness and injury, employers are recognizing that the overall long-term health of their workforce and their families has a dramatic impact on productivity.

A recent Benefits Quarterly⁴ article puts it this way, "An ACO is an evolved partnership between the healthcare delivery system, involving the physicians, hospital and [payer] in ways that align all parties' financial interests, clinical processes and operations to deliver cost-effective, quality care around a commonly accepted set of goals for improved results. For employers, the method to capturing the value of these emerging delivery models is to have a broad understanding of the evolving payer and provider marketplace...and how smart decisions today can improve the future landscape of healthcare."

To succeed in this environment, ACOs and other risk-bearing provider organizations must more closely collaborate with payers, employers and patients to achieve the Triple Aim: better outcomes, lower costs and a more positive patient experience. Thus, it's critical to put the right tools in clinicians' hands to help all patients return to health faster, safely and efficiently. By applying evidence-based guidelines to manage injury and illness, and leveraging analytics to uncover opportunities for organization-wide improvement, ACOs stand to gain on three fronts: Demonstrating quality of care, enhancing financial performance, and improving population health.

THREE REASONS ACOS SHOULD USE EVIDENCE-BASED GUIDELINES AND ANALYTICS

1. DEMONSTRATE QUALITY OF CARE

As provider organizations migrate from fee-for-service to value-based models, they are incented to meet a range of quality performance measures related to care coordination, patient safety, preventive health and chronic condition management. While evidence-based clinical guidelines have been used for some time to improve quality, using them along with disability duration tables and advanced analytics at the point of care holds even greater promise for an industry looking to bend the cost curve down while improving quality and outcomes.

Traditionally, most physicians are not trained in disability management and may not know how to determine the length of time it may take for a patient to heal and return to their normal lifestyle. Disability duration tables provide an objective and consistent basis for setting return-to-health expectations. The tables are informed by millions of real-world cases, which in turn helps clinicians better plan and manage the patient's care. The duration tables include timelines that are broken down by activity levels to further guide return-to-health efforts.

Rarely will there be a generic patient however, so personalization is also important. With point-of-care predictive modeling capabilities, clinicians can personalize recommendations based on factors like age, gender, geographic location, comorbid conditions, etc. Having the ability to combine personalization with optimum recovery timeframes at the point of care facilitates an informed dialogue between doctor and patient. From there, care and resources can be coordinated appropriately toward the goal of returning patients to wellness as quickly and efficiently as possible, while managing setbacks if they arise.

From an organizational standpoint, this approach provides data needed to drive improvements across the organization that make care better and more efficient. According to Health Affairs data⁵, \$992 billion of healthcare spending is wasted – excluding fraud and abuse – every year. Organizations have enormous opportunity to use advanced analytics to tackle inefficiency and waste, for example:

- Identify and manage variations in care and utilization inconsistencies
- Identify and implement best practices for treatment planning and management
- Identify cohorts of patients and conditions for proactive intervention and management

With evidence-based guidelines and analytics in hand, clinicians can better manage care to expected recovery times, provider and payer organizations can reduce costs, and patients can return to health in a safe and timely manner.

2. ENHANCE FINANCIAL PERFORMANCE

Historically, payers have been the go-between with providers and patients. However, ACOs have now entered this space to change the way employers purchase healthcare for their employees. There are several models, such as providers forming their own health plans, collaborating with health plans, or going directly to employers. With more flexibility to develop partnerships like these, ACOs can pursue different strategies for generating revenue, expanding their patient base and growing market share.

“Employers may be able to help curb the rising cost of their healthcare spending, and ACOs are betting on being able to deliver better care at a lower cost while increasing their share of the market. One of the top priorities of an ACO is to attract an increasing number of patients into a more efficient system.”⁶

For many ACOs and other risk-bearing providers, the push to make up for volume losses resulting from new clinical and operational efficiencies prioritizes two options: attract new patients and more closely manage costs. Moreover, directing patients to more efficient providers benefits the bottom line for ACOs, employers and payers.

Right from the start, ACOs and provider organizations can leverage their reputation and previous successes to attract new business from payers and employers. Organizations that demonstrate how the use of proven, evidence-based clinical content and analytics helps individuals get back to full health and full activity faster will have a strong differentiator.

To create steady growth however, ACOs must also manage resources and utilization. Of the \$992 billion in wasted healthcare spending each year, \$158 billion to \$226 billion is a direct result of overtreatment. Moreover, 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes.⁷ Organizations that use evidence-based protocols effectively can succeed at driving out these costs. Better care planning, waste avoidance and cost management result from keeping a focus on optimum duration timeframes and personalizing treatments based on a patient’s needs.

3. IMPROVE POPULATION HEALTH

In the grand scheme, it’s simply better for patients to return to full health, normal activity, and productive work as soon as possible. This goes beyond recovering from an illness or injury to successfully transitioning to a state of health and wellness.

There are significant proven negative effects of being laid up that apply to people in general: depression, anxiety, stress, inability to fulfill normal responsibilities, loss of income, etc. With such far-reaching negative impacts, returning to health is critical. According to James Talmage, MD, “There is a large and growing body of scientific evidence that return-to-work (and activity) usually provides significant overall health benefits, and staying off work needlessly results in poorer overall health outcomes. Employers, employees (patients), and insurers all benefit from individuals returning to work in usual time periods.”⁸

ACOs and other provider organizations are well positioned to successfully return patients to health activity levels faster. When physicians and other care team members look at the patient’s entire episode and provide personalized, coordinated care, they improve total patient health and well-being. Likewise, each patient returned to a state of health contributes to the overall health of the community in which they live.

CONCLUSION

Changes in the U.S. healthcare system driven by the ACA will continue to unfold. As ACOs and other risk-bearing providers, payers and employers embrace value-based care, putting evidence-based practice guidelines and analytics capabilities in the hands of clinicians helps return patients to their active lives safely and efficiently. At the same time, this approach enables organizations to gather and apply data-driven insights to demonstrate quality of care, enhance financial performance, and improve the health of the populations they serve – and achieve their goals for value-based care.

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