

The transition from “volume” based to “value” based care is a momentous shift for healthcare providers. Steps, methods and tools are available to help support and guide this transformation.

# Bridging the Divide

Transitions to Cross-Continuum Collaborations in Healthcare

Irving Stackpole

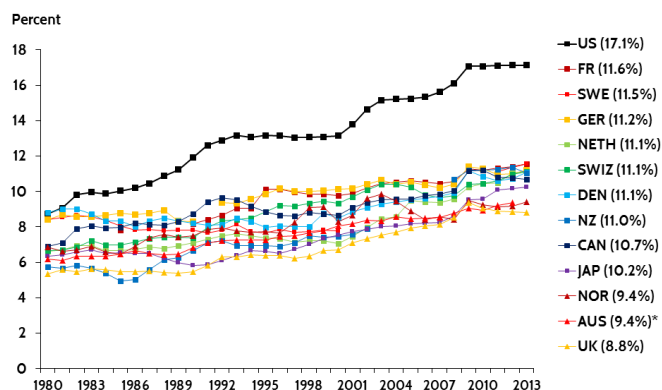
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## Where We Are Now: Situation Assessment

The [US spends far more on healthcare](#) than other developed nations and by most measures the results are subpar. There have been many efforts to slow the rise in healthcare costs and improve

**Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013**



\* 2012  
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.  
Source: OECD Health Data 2015.

value, such as utilization controls, prequalification for services, incentives for lower-cost alternatives and a variety of other mechanisms. Most of these efforts have not succeeded.

There is almost no argument that the United States' healthcare delivery system is inefficient, that it delivers poor value for the money spent, and among the most frequently cited causes for this are fragmentation and

lack of collaboration between and among providers. Because [Stackpole & Associates](#) works across virtually all the healthcare segments, we see this every day. In a new set of initiatives to control costs and improve value, the [Centers for Medicare and Medicaid Services](#) (CMS), the agency responsible for approximately 65% of healthcare spending the United States, has now set its sights on a new goal.

### Follow the money!

By the end of 2016, 30% of [Medicare payments will be based on value](#), rather than fee for service (the dominant current model for payment), and the CMS has set the goal of 50% by 2018. This change is intended to both slow the increase in healthcare spending in the US, and to improve the value of services provided. These changes will lead the way for other payors and intermediaries.

The transition from "volume" based payments (fee-for-service) to "value" based payments is momentous. For decades, more services provided to patients or "consumers", translated to higher provider payments. Several new models being piloted by CMS not only limits the amount paid for an entire episode of care, but the amount paid is intended to cover all providers.

Healthcare managers in every segment are struggling with how to adapt to this extraordinary goal. The only way such a transition can be accomplished is for providers in the various segments to cooperate and collaborate. From the outside looking in, this seems obvious. If Mrs. Smith is admitted to the hospital because of a fractured hip requiring surgery, then is transferred post operatively to a skilled nursing center for rehabilitation, and then back to her residence with

home healthcare and some rehab equipment, logic assumes that this entire “episode” of care would be coordinated – but the facts are anything but logical. Mrs. Smith would be exposed to at least five different regulatory and payment pathways, none of which is coordinated with the other.<sup>1</sup> Moreover, she would be exposed to at least three, and potentially four different pharmacy formularies for (in many instances) the same medicines.

Without attempting to restructure any of these regulatory or payment pathways, CMS has pointed to the goal and told all these distinct providers that it expects collaboration.

### Tower of Babel

These systems were never intended to cooperate. Regulations between and among hospitals, (even different types of hospitals), home health agencies, home medical equipment suppliers, nursing homes, pharmacies, home and community-based services, transportation, and others are not designed for collaboration. The many agencies which develop and enforce rules for both delivering and paying for services speak different languages; have different systems and codes which in many ways prevent cooperation!

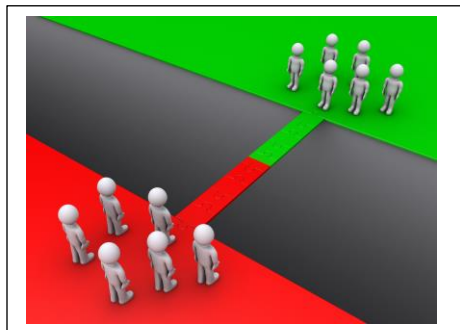


Organizations which have historically operated in their own isolated segments will be required to collaborate in order to achieve the value-based payment goals set by CMS. Even more challenging, in our experience, is

that providers, which have been competitors, have to [learn to collaborate](#) in order to avoid penalties, to continue to survive and not be excluded from “preferred provider” networks. CMS is leaving the “how” of this transition up to providers and intermediaries, and have only pointed to the horizon. The risks are great, to say the least. The historic fragmentation of healthcare is built into everything we do – from regulations, to payments, to the very language we use to describe the services performed. In this vertically partitioned environment, how can differences be bridged, allowing the level of cooperation and collaboration, which will quickly be necessary?

<sup>1</sup> As an example, services delivered to Mrs. Smith include and may not be limited to: 1. hospital care (Medicare Part A); 2. physician services (Medicare Part B); 3. home medical equipment (different part of Medicare Part B); 4. medications (Medicare Part D or another channel); and 5. home healthcare through “original” Medicare or “Medigap” coverage.

## Collaborate or Die? – Bridging the Divide



Managers in a wide array of organizations will soon need to reach collaborative decisions about the best or "ideal" care for a particular patient. For example, deciding if Mrs. Smith should be referred to a nursing center for rehabilitation, or if she can be safely referred to home are not discussions which have taken place between and among hospitals, nursing centers, home medical equipment suppliers and home health agencies ("actors"). Rather, each actor has competed for its slice of the patient's economic pie, striving only to maximize its own

benefit. Hospitals will be [penalized \\$528 million for readmissions](#) in the next fiscal year. These penalties are often the direct result of not having cross-continuum, collaborative discussions. Because of these penalties, the conversations have started!

There is also an urgent need to develop more sensitive and predictive local models built on data, rather than national statistics, competitive position or anecdote alone. Healthcare providers must learn to use data in order to deflect the drive of intermediaries using cookie-cutter approaches to care utilization. For example, why would Mrs. Smith, the postoperative hip replacement patient, receive 20 days of nursing center rehabilitation in Chicago, and only five days in Boston? These variations are real, and occur too often. In an attempt to control these variations, intermediaries contracted with CMS enforce rigid rules on care delivery, which are not based on dialogue with the care providers, but rather on models derived from national or regional statistics. If the hospital, nursing center, medical equipment supplier and home health agency work in closer communication about Mrs. Smith, they could be more assertive with her intermediary, making the case for the most appropriate level of care, rather than a cookie-cutter, one size fits all approach.



## Steps to the Dance: Take Your Partner By the Hand ...

The steps to develop a cross-continuum collaborative for care are far from intuitive, and have been undertaken by only a [few organizations](#). Programs and approaches which effectively manage care between and among discharging hospitals, post-acute care providers, home and community-based services, for example, are rare. And [too often they don't succeed in producing the efficiency or productivity](#) hoped for, and so they are not sustainable.

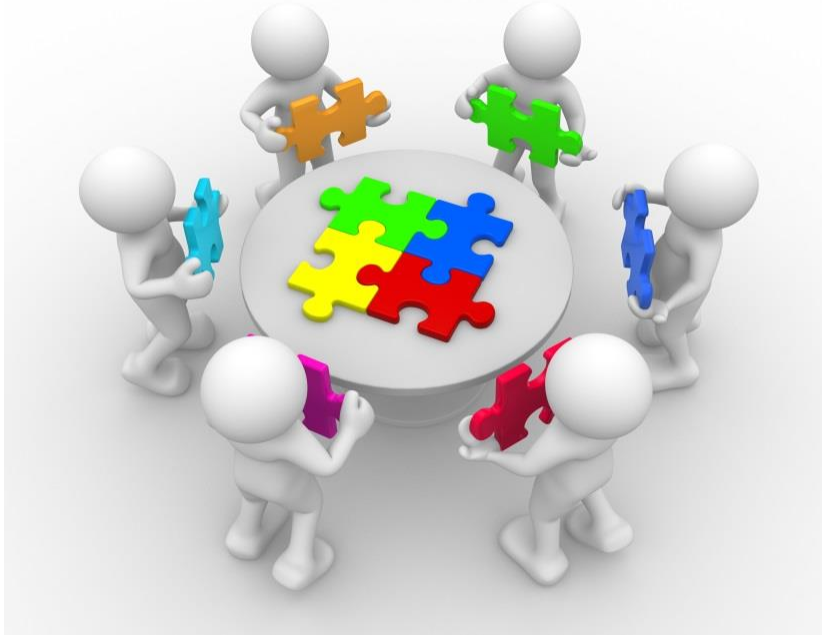
To survive and thrive in a value based payment environment, providers must quickly learn new approaches, develop deep and lasting collaborative relationships and do so in a way that preserves the best of the care and support they provide patients, clients, end-users and consumers.

But how? How do we build collaboration where there is currently intense competition and secrecy? How can we create teams that are efficient, productive and sustainable?

### Steps to the dance...

Clients and colleagues from across the healthcare spectrum are asking, “Where do we start?”

How can a disparate group of actors move effectively and efficiently from vision to the implementation of cross-continuum collaboration? When no one actor has all the answers or the authority, the usual committee of working group isn’t adequate to the task. While there’s no firm formula, these are steps derived from benchmark models<sup>2</sup> which Stackpole & Associates has employed to guide these initiatives.



1. Leadership: In the earliest stages of any new initiative, leadership is critical. It is not an accident that the earliest forms of value based payment, such as accountable care organizations (ACOs) are structured with a designated leader around which the initiative is undertaken. Leadership in terms of visibility, support, focus and endurance is critical to the success of cross continuum collaboration initiatives. Moreover, leadership can be measured and its impact monitored. Stackpole &

Associates uses an array of tested measures for these purposes, and can customize skill building and training where and when required.

<sup>2</sup> See: Loehrer S, McCarthy D and Coleman E. Cross-Continuum Collaboration in Health Care: Unleashing the Potential. Population Health Management 2015

2. Trust: If the initiative starts with one or more of the actors saying, “What’s in it for me?” this “extractive” type of relationship may be successful only in the short run, if at all. Long-term collaboration across a complex continuum, fulfilling the needs of high acuity, low acuity, dual eligible and privately insured consumers, as well as the needs of the participating providers will require give and take among all actors in any given marketplace area. This long-term success requires commitment among many different individuals and organizations, and research by Stackpole & Associates and others clearly shows that this level of commitment is highly correlated to organizational trust. Trust is built through long-term relationships where both give and take are experienced by everyone at the table. Stackpole & Associates uses survey and assessment techniques to measure trust within workgroups by assessing credibility, decision participation, empowerment and feedback.
3. Shared experiences: Collaborating providers benefit from shared site visits among a wide variety of participating staff. “Walk a mile in my shoes” and each staff person learns a lot, perhaps building some enduring relationships. These relationships cement commitment and ties between and among the individuals as the initiative rolls forward. We know from experience that it is the commitment of individuals to vision and mission, which allows any initiative to succeed.
4. Early wins: Start small, with modest expectations, and early success will reinforce motivations. Early meetings and discussions and site visits will be seen by many of the individuals as an imposition. “Why am I doing this?” “If my boss only knew how much work was waiting for me, she wouldn’t have sent me here!” Early victories in small scale, but important matters – like harmonizing language around similar tasks – can also lead to scalable models further down the road.
5. Inclusive: To improve outcomes and the patient/family experience, it is important to involve individuals with completely different levels of knowledge than the “usual suspects”. Housekeeping, grounds maintenance, drivers, and kitchen staff may be as critical as the medical director or head of operations. This level of collaboration will be truly disruptive in many organizations. (See #1 & 2 above.), Leadership, commitment around a shared vision and a long-term approach will help each of the actors to get past barriers of exclusion.
6. Data, data, data: The initial and intermediary changes required by CMS, and called for by virtually all intermediaries are built upon, and will be measured by data. Both quantitative and qualitative information are important, and those involved in collaborative efforts will need to (in many cases) create a whole new lexicon of terms to share information effectively. Building the skills of measurement and quantification among all levels of staff is critical. Every participating provider organization must find ways to build the numeracy skills of their staffs.



7. Focus on end-users: Patients, clients, consumers, guests, customers are only a few of the names assigned by various types of providers to the end-users of the services. In wrestling with the complexity of the historically fragmented health care system, the focus must remain on the patient and his or her family. Population health, the experiences of families and the well-being of our communities are the ultimate goals, and represent the highest levels of efficiency.

In the monumental transition from fee-for-service payment and regulation to value-based payment and structures, the health of populations will become equal to the health of providers' bottom line. This requires dramatically new collaborations across the continuum of healthcare and service providers.

#### **ABOUT THE AUTHOR**

Irving Stackpole, RRT, MEd, President of Stackpole & Associates has over 40 years of experience in healthcare, senior living and human services throughout the US and internationally.

#### **ABOUT STACKPOLE & ASSOCIATES**

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- Strategic planning;
- Market research;
- Identifying & securing sustainable sources of referrals;
- Marketing communications campaigns, and;
- Customer / patient experience management.

Stackpole & Associates has a deep vertical expertise in organizational development in the healthcare and seniors' services segments, having conducted ground-breaking projects, market research, and achieved successful, stable transitions in many settings. For 25 years, the company has worked with providers, developers, hospitals, clinics, governments and agencies.

Contact Stackpole & Associates today to learn how we can help you and your cross continuum collaboration initiative, develop, grow and thrive.