**Special Article**

# Volume to Value in Healthcare: Personnel and Organizational Management

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**Abstract**

Quality healthcare and patient satisfaction are significant, and healthcare facilities are expected to use medical resources appropriately. Volume-based and value-based healthcare delivery system issues were identified, as well as each of their strength and barrier potential for healthcare management. Centers for Medicare & Medicaid Services (CMS) reimbursed hospitals based on the quantity of services provided, once termed fee-for-service, instead of how well the hospital provided their services. The purpose of this paper is to discuss and describe the potential impact of shifting from a volume-based healthcare delivery system to one of value-based. The role of the Clinical Nurse Leader (CNL) in the healthcare delivery system includes implementing evidence-based practices to facilitate quality and continuity of care, cost effectiveness, and thus positively impacting quality healthcare.

***Key Words:*** *Value-based, volume-based, healthcare delivery systems, quality health care, clinical nurse leader.*

## Healthcare Delivery Systems

The healthcare delivery system is a world of its own. As complicated as the healthcare delivery system appears to be, it is composed of three major elements – the patients, the providers, and the payers. The patients and the providers typically go without explanation. The payers, however, can be either first-, second-, or third-party payers. The first-party payer is the patient, second-party payer is the facility providing care, and third-party payer is a mix of private insurance and government entities. Medicare and Medicaid are examples of third-party payers.

During recent decades, there has been national conversation concerning the expanded expense of healthcare. More importantly, the increased costs were not leading to better patient outcomes. The healthcare delivery system would once *take a stab* at any and everything to conclude to a diagnosis. This mentality cost third-party payers a considerable amount of money due to the third-party payers paying for what was done, rather than how well it was done. Quality healthcare and patient satisfaction are significant, and healthcare facilities are expected to use medical resources appropriately. Surprisingly, quality healthcare was not always the norm.

## Volume-based Delivery System

For many years, Centers for Medicare & Medicaid Services (CMS) reimbursed hospitals based on the quantity of services provided, once termed fee-for-service, instead of how well the hospital provided their services. For example, if a facility performed a computed tomography (CT) of the head every time a patient came into the facility, that facility would receive a set amount of funding. This allows healthcare facilities to accumulate substantial amount of reimbursement from third-party payers. So, where did the problem lie?

The dilemma in the volume-based healthcare delivery system era was just that; substantial amounts of reimbursements from CMS to

healthcare facilities. If the healthcare facility *did* more, they *got* more. It has been argued that a volume-based healthcare delivery system inspires overutilization of resources (Butcher, 2017; Combes & Arespacochaga, 2013). According to Williams (2017), volume-based healthcare delivery generates excessive volume of care, greater intensity of care within an episode of illness, and can lead to under provision of services that are not separately billable. Not every person that comes into the emergency department with a headache requires a CT. This is simply a waste of that facility's resources, while the facility receives funding for a service that seemed a bit overzealous. Overutilization of resources drastically increased healthcare cost. Neither the patient nor the provider could *feel* the impact of misuse and overuse of medical services, ill-advised procedures, and elevated levels of spending. Less than 10 years ago a new law was signed into congress that forced healthcare facilities to reevaluate their spending and the value of care provided to their patients.

**Value-based Delivery System**

Value-based delivery system challenges hospitals to administer quality healthcare by providing incentives to hospitals that do such. King & Gerard (2016), defines value-based purchasing as the method of payment by CMS for in-hospital stays based on HCAHPS and patient outcomes. HCAHPS, or Hospital Consumer Assessment of Healthcare Providers and Systems, is a standardized tool used to measure the patient's belief of the quality of care received and is part of the value-based purchasing initiative by CMS (CMS, n.d.).A partnership between CMS and Agency for Healthcare Research and Quality (AHRQ), led to hospital consumer assessment of healthcare providers and systems (HCAHPS) survey.

After discharge, the patient receives a HCAHPS survey with twenty-seven question regarding the most recent inpatient visit. Of the questions asked, 66% are related to critical features of the inpatient stay (CMS, n.d.). The discharged patient gets the opportunity to express their opinion of the quality of care that the hospital provided. The National Quality Forum declared public support of HCAHPS in May of 2005 (CMS, n.d.).

The Patient Protection and Affordable Care Act (ACA) or at times referred to as "Obamacare" was a comprehensive healthcare reform law signed in 2010 that reconfigured how society thought about healthcare quality and Medicare and Medicaid beneficiaries. The intent for the law were to make cost-effective health insurance available, broaden the Medicaid program, and lower the overall cost of healthcare (Levey & Kim, 2017). ACA pushed that a volume-based healthcare delivery system should not be the norm and that healthcare facilities needed to be held to a higher standard for providing affordable, high-quality, value-based care (Abrams et al., 2015).Also set into motion by ACA was a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care (Kaiser Family Foundation, n.d.)

CMS already had the authority to conduct demonstrations and pilot programs but were bond by different legal and political constraints. The CMS Innovation Center after ACA of 2010 allowed CMS to reach new heights. The law authorized the exploration and expansion of healthcare delivery models that reduce cost while preserving or improving the quality of healthcare (Barr, Foote, Krakauer, & Mattingly, 2010).

**Effects on Healthcare Management**

CMS and health care reforms are not exactly asking healthcare facilities to do more with less; but more so demanding those facilities to vow to treat patients with effective, efficient, and high-quality care. There has undoubtedly been a change in the way of thinking to adjust to a new way of reimbursement; a way founded in quality. The Health and Medicine Division of the National Academies of Science, Engineering, and Medicine, defines healthcare quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Health and Medicine Division of the National Academies of Science, Engineering, and Medicine (n.d.). What this means for stakeholders, whether business or clinical, is a demand for high-impact leadership and systematic quality improvement. Care should be grounded in evidence-based practice and provided in technically and culturally competent manner with

effective communication and shared decision making; unlike the earlier volume-based healthcare delivery model. High-impact leadership is essential to success for leaders in their continual transition from volume-based healthcare delivery systems to value-based healthcare delivery systems. The Institute for Healthcare Improvement (IHI) developed a framework termed "Triple Aim" as well as a framework for high-impact leadership to aid in achieving the Triple Aim. The Triple Aim, which is better care, smarter spending, and healthier people, goal is to address the need for improvement at all levels of healthcare. As part of the push for quality improvement healthcare leaders and their staff should focus on improving safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity as highlighted by the Health and Medicine Division of the National Academies of Science, Engineering, and Medicine (Agency for Healthcare Research and Quality, n.d.). Healthcare leaders can use these aims when developing quality and safety strategies for their facilities. Healthcare leaders must consider and be willing to adapt to the complexity of systems to be effective in the management and continuous improvement of their organizations.

The American Hospital Association offers five toolkits to help healthcare facilities cut back on costly and inappropriate services while improving quality care (Combes & Arespacochaga, 2013). Healthcare facilities and their management core must accept responsibility to encourage suitable and constant use of healthcare resources and supply providers the tools to better communicate with patients about appropriate use of resources. The has been enormous progress towards advancing the quality of care, and multiple agencies urging healthcare facilities to become better and provider better care, and yet as a society there is still work to do.

## Conclusion

The role of the Clinical Nurse Leader (CNL) to oversee the lateral integration of care within a healthcare delivery system. Facilities that have CNLs on their team offer the healthcare facility a leader within a microsystem implementing evidence-based practices to facilitate quality and continuity of care. It is understood that providing continuity of care is a challenge without concrete solutions. Excessive costs of healthcare can be contributed to disjointed care, medication errors associated with ineffective communication, frustration, poor patient outcomes, increase readmission rate, and increased waste. All of which may result in insurance companies changing reimbursement policies for poor or fragmented care. By working at the microsystem level, the CNL is equipped with the knowledge and skillset to positively impact quality healthcare on the front line.

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