

HFMA'S VALUE PROJECT

Value in Health Care:
Current State and Future Directions




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ABOUT THE VALUE PROJECT

f all the transformations reshaping American health care, none is more profound than the shift toward value. Quality and patient satisfaction are being factored into Medicare reimbursement, while private payers are pushing for performance and risk-based payment structures. At the same time, rising healthcare costs are creating more price sensitivity among healthcare purchasers, including government agencies, employers, and, of course, patients themselves, who are being asked to pay higher premiums, copayments, and deductibles for their care.

Hospitals have always cared about quality because they are fundamentally dedicated to patient well-being. But today's pressures make it financially imperative to develop collaborative approaches that combine strong clinical outcomes with effective cost containment.

HFMA's Value Project aims to help guide the transition from a volume-based to a value-based healthcare payment system. With the support of 17 leading hospitals and health systems (listed on the inside back cover of this report), which serve as the project's steering committee and research sponsors, HFMA has engaged in a series of interviews with finance and administrative leaders and their clinical partners at providers who are leading the transition to value, including:

Advocate Health Care	Lee Memorial Health System
Baptist Health South Florida	The Methodist Hospital System
Baylor Health Care System	New York-Presbyterian
Bellin Health	Novant Health
BJC HealthCare	Partners HealthCare
Bon Secours Health System	Rush University Medical Center
Catholic Health East	Scottsdale Healthcare
Catholic Healthcare West	Sharp HealthCare
Cleveland Clinic	Spectrum Health
Geisinger Health System	Texas Health Resources
HCA - Hospital Corporation of America	UAB Medicine - UAB Hospital
Intermountain Healthcare	Unity Health System


HFMA has also interviewed a range of organizations representing the perspectives of patients, employers, commercial payers, and government agencies, including:

The Access Project
American College of Physician Executives
Blue Cross Blue Shield Association
Catalyst for Payment Reform
HFMA-UK
Institute for Healthcare Improvement

In addition, HFMA has conducted two industry surveys, the first on the current state of value in health care and the second on future directions for value in health care. The results of these interviews and surveys form the basis of this report, which defines the concept of value in health care, describes the current state of value and the capabilities that are being developed by providers actively engaged in value-based initiatives, and identifies likely future directions of a value-based healthcare system.

This report is the first in a series of publications, educational events, and tools that will together form HFMA's Value Project. For additional information, visit the Value Project website at www.hfma.org/ValueProject.

EXECUTIVE SUMMARY

f the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value. Value is driving a fundamental reorientation of the healthcare system around the quality and cost-effectiveness of care, for, as in any industry, value in health care is defined through the relationship of these two factors: the quality of care and the price paid for it.

Over the years, the mechanisms used to finance and measure healthcare delivery have obstructed the ability of patients and other purchasers of care to perceive value, as detailed in the initial sections of this report. A payment system in which a combination of employer contributions and government funding is the dominant payment source means that patients' out-of-pocket expenses typically bear little relationship to the total price of care. Price controls and cost-shifting have created different pricing structures for different purchasers of care. Quality metrics have focused on process-related measures that tell patients little about the functional outcomes they might expect from care.

The move toward value is starting to push these obstructions aside. Patients, employers, government agencies, and health plans increasingly want to know what they can expect to receive for what they pay for care. They are seeking out providers who will give them this information and follow through with cost-effective care. They are, in other words, expecting to get value.

How should providers respond to the demand for value? In interviews with leading provider organizations across the country and surveys of the field, HFMA has identified four capabilities that organizations should develop to prepare for a value-based healthcare system. These include:

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

"The Current State of Value in Health Care," which forms the central section of this report, details essential skills within each of these four capabilities that healthcare organizations should begin to develop now. Organizations that are actively working to improve the value of care offer examples of how to develop and apply these skills. Advocate Physician Partners, for example, provides a non-employment model of physician engagement for the people and culture capability, while Spectrum Health describes how interdisciplinary teams of clinicians and finance staff can collaborate on creating metrics that provide actionable data for business intelligence. Rush University Medical Center shares its approach to identifying variability within clinical processes to drive performance improvement. And Sharp HealthCare describes an innovative risk management program that helps keep capitated patients in network and ensures the continuity of their care.

Later in the report, focus turns to "The Future State of Value in Health Care." This section outlines a series of assumptions that will push the healthcare system in two directions. The first is a trend toward greater provider integration, as accountability for care outcomes spreads across the care continuum. The second is a trend toward greater assumption of risk by providers, as the healthcare system seeks to reduce costs through better management of population health.

The trends toward increased provider integration and greater provider assumption of risk will not necessarily push all healthcare organizations in the same direction. Instead, a range of strategies will likely be available, combining different degrees of integration and risk. Based on models that are emerging today, the report highlights five possible future value strategies that healthcare organizations could pursue, detailing key capabilities, possible benefits, and potential challenges for each.

Throughout the research process for this report, the healthcare organizations HFMA interviewed made reference to the "value journey." This report begins with where our healthcare system is today, follows promising paths that innovative healthcare organizations are pioneering, and describes possible new destinations for healthcare organizations in a value-based future. Like the value journey, HFMA's Value Project is just beginning. This report is a first step along the way.

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DEFINING VALUE

What is value in health care? In most industries, value resides at the intersection of a purchaser's perception of the quality of a good or service and the amount he or she is willing to pay for that good or service. If you had to pay \$15 for a cheeseburger at a fast-food restaurant, you would probably not think that you got good value. But if you paid the same amount for a well-prepared filet mignon dinner, you would probably think you received value, just as you might in a \$3 cheeseburger. Value, in other words, is a concept of relative worth. It is a function of quality over payment, and a product's value is increased by an improvement in quality, a reduction in the amount paid, or both.

The same definition should apply in health care, and for most commentators on the question of value in health care, it does.¹ However, measuring value in health care remains elusive for several reasons. First, *there is no clear, consensus definition* of what constitutes “quality” among providers, let alone purchasers, for whom a “quality” outcome will often vary according to such factors as expectations, age, and general health. Second, in many cases, *the full amount paid*

for health care is not apparent. Payment for a full episode of care (for example, pre-acute, acute, and post-acute services related to a surgical procedure) is made to a fragmented collection of providers. Also, payment for care is often divided among multiple purchasers: the patient (primary purchaser); employers and/or state and federal programs, such as Medicaid and Medicare (secondary purchasers); and perhaps a health plan (serving as an intermediary between purchasers and providers). All of these purchasers have overlapping, but not identical, interests in the quality and price of the care provided. And third, under the current payment system, *providers typically are not compensated for producing value*; instead, they are economically rewarded for the volume of services they provide.

HFMA's Value Project is intended to help healthcare organizations create value for the multiple purchasers of health care. In this report and in subsequent publications, educational opportunities, and web tools produced for the Value Project, HFMA will do the following:

- Define the practices of providers who are leading the way toward a value-based healthcare system
- Describe the primary capabilities that healthcare organizations will need to develop in the areas of people and culture, business intelligence, performance improvement, and contract and risk management to improve the value of care provided
- Provide specific strategies, tactics, and tools that healthcare organizations can use to build, enhance, and communicate their value capabilities
- Identify the trends today that are defining the future state of value in health care and describe new care delivery models that could help healthcare organizations create value

THE VALUE EQUATION RECONSIDERED FOR HEALTH CARE

$$\text{Value} = \frac{\text{Quality}^*}{\text{Payment}^\dagger}$$

* A composite of patient outcomes, safety, and experiences

† The cost to all purchasers of purchasing care

¹ Harvard Business School professor Michael Porter, for example, defines value in health care as outcomes (the indicator of quality in Porter's formulation) relative to costs (the total amount paid for the full cycle of care). See Michael Porter, “What Is Value in Health Care?”, *New England Journal of Medicine* (Dec. 23, 2010): 2477–2481.

DEFINING VALUE

TOWARD A PURCHASER-CENTERED VALUE EQUATION

Creating value in health care will require bringing payment and quality—the two factors of the value equation—to the fore and, as in other industries, defining them around the purchaser’s needs.

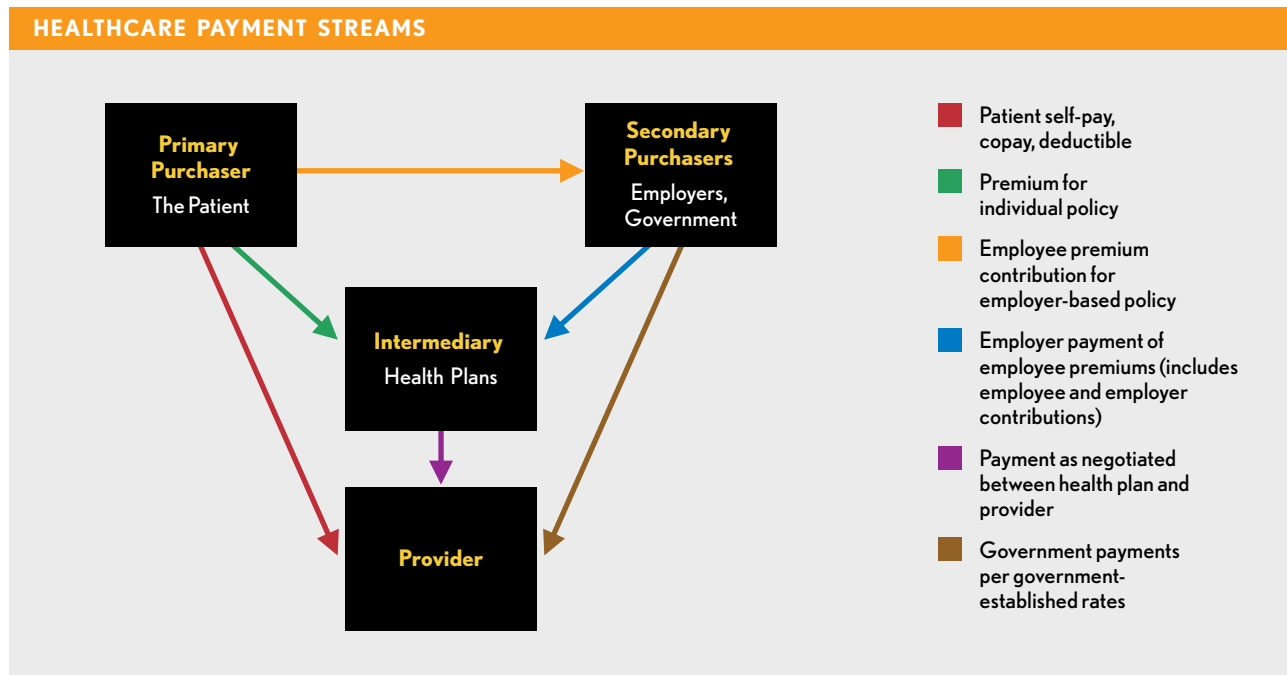
PAYMENT

To avoid confusion, this paper uses the term “payment” to describe the cost of purchasing services—the amount paid by the patient, employer, and government purchasers—and will use the term “cost” to describe the healthcare provider’s cost of providing the service. In a purchaser-centered value equation, the provider’s cost is relevant to the purchaser only to the extent it drives the amount of payment. The cost of providing care is, nonetheless, an important consideration for providers, the main audience for this report, who are tasked with maintaining financial viability while improving quality of care.

With respect to the value equation, the central problem with payment in the current state is that the purchaser who initiates a purchase of healthcare services—the patient—will often have little or no sense of the total price of the services purchased. The diagram below illustrates how payment streams flow within the current system.

The greatest patient sensitivity to payment for a particular service occurs, first, along the payment stream highlighted in red, which involves direct payment from the patient to the provider in the form of self-payment, copayments, or deductibles, and second, along the payment stream highlighted in green, which represents self-insured individuals who must pay their full premium. If, however, the patient has employer-based insurance or is a Medicare beneficiary with a low copay or deductible, sensitivity to the total payment for a service is significantly reduced. Although patients are in fact paying a significant amount for their care in the form of monthly premium contributions deducted from their paychecks or in taxes paid to fund state and federal programs, these payments are largely out of mind for patients who will instead focus on the “out-of-pocket” amount of a copay or deductible paid at the time of care.

An additional complication in health care’s current state is that payment, from a purchaser perspective, is fragmented among different providers. Take a procedure such as a joint implant, which will require preliminary visits to an orthopedic specialist’s office, a procedure (inpatient or outpatient) at a hospital, follow-up visits with the orthopedic specialist, physical therapy sessions, and



other related services. The services of the different providers in this scenario will be billed separately, even though all these services together define a single episode of care.

Without a consolidated bill, it is difficult for the individual patient to fully understand the total amount paid for care.

On the other hand, employer and government purchasers of care and health plans have high sensitivity to the total amounts paid for health care, and are much more attuned to the total price of care. This has several implications for the value equation.

First, employers and health plans have an incentive to shift more of the payment burden to patients in the form of higher copays, deductibles, or premium contributions to make patients more price-sensitive. The rise of consumer-directed health plans since the early 2000s is an example of such an effort, but these plans have had mixed results, especially with respect to the quality of care.² More recently, employers have begun shifting to employees a higher percentage of the overall premium paid for their coverage. According to the Kaiser Family Foundation, the employee percentage of the premium held steady at 16 percent from 2002 through 2008, but increased to 19 percent as of 2010.³ As noted earlier, an employee may not make a direct connection between a monthly premium contribution and payment for an episode of care, but as the percentage of employee copays and other direct care payments increases—in addition to premium payments—the employee should become increasingly sensitive to the overall price of care.

Second, purchasers of all types have an incentive to spend money on preventive programs or care coordination programs if such programs have the effect of reducing overall payments for health care (this is especially true for employers if savings can be seen in the near term). Employer-sponsored wellness programs have been around for some time, but the significant rise in such programs in recent years suggests that employers have reached a point where the rising costs of health care justify an investment

in employee wellness.⁴ Health plans and employers are still trying to quantify the ROI for such programs, but some studies have indicated positive results.⁵

Third, and perhaps most important, employer and government purchasers of care are heavily invested in finding the right balance to the value equation, and have significant influence over both health plans and providers. These purchasers have already begun influencing the payment system. The Centers for Medicare & Medicaid Services (CMS), for example, has announced its intention to use value-based purchasing “to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.”⁶ And both individual employers and employer coalitions are actively working with health plans and providers to move healthcare payment from an emphasis on volume to a focus on value.⁷ In many instances, these value-based payment methods will push providers toward acceptance of more performance risk and toward greater collaboration—and integration—with other providers across the care continuum.

The trend in payment is thus to give the patient a better sense of the price of care, shift more healthcare dollars to preventive and primary care, and change the payment system in ways intended to improve quality, stabilize or lower prices, and promote the coordination of care among providers.

QUALITY

Identification of quality, the value equation’s numerator, is ambiguous at best. The biggest problem, of course, is that there is no comprehensive, standard definition of quality for the healthcare industry. CMS has developed core measures that have been adopted by many other payers, but with respect to clinical treatment, these are largely focused on processes that may be indicators of, but are at least one step removed from, actual outcomes. The outcome metrics currently employed are fairly blunt indicators of quality, emphasizing either mortality or readmission rates within a certain period

² See, for example, Melinda Beeuwkes Buntin et al., “Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality,” *Health Affairs*, Web Exclusive, vol. 25, no. 6, November/December 2006, pp. w516–w530.

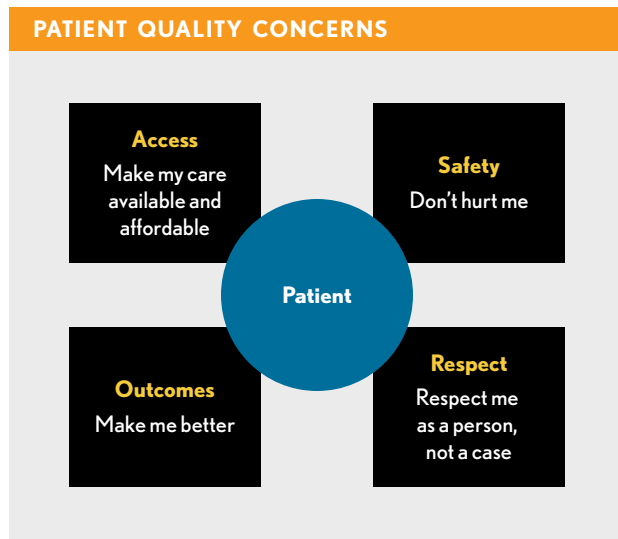
³ “Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999–2010,” *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010* (Sept. 2, 2010).

⁴ *Employer Investments in Improving Employee Health*, a January 2011 report by the National Business Group on Health and Fidelity Investments, found that the ratio of the aggregate number of employee wellness programs to be implemented in 2011 compared with the aggregate number being discontinued was 8:1.

⁵ See, for example, John Commins, “Wellness Programs Show Hard-dollar Savings,” *Health Leaders Media* (Feb. 28, 2011).

⁶ Centers for Medicare & Medicaid Services, “Hospital Inpatient Value-Based Purchasing Program Final Rule,” *Federal Register*, vol. 76, no. 88 (May 6, 2011), p. 26490.

⁷ See, for example, the agreement between home-improvement retailer Lowe’s, Inc., and the Cleveland Clinic regarding heart surgeries for Lowe’s employees and their dependents, described on p. 33 of this report.



of time following a procedure or admission. Moreover, these outcome metrics emphasize adverse events, not the positive outcomes that purchasers expect from care.

Patient Concerns

In beginning to work through a definition of quality of care, one must start with the patient, the recipient of care. And for the patient, the quality of care depends on a combination of the factors highlighted in the exhibit above.

Access to care—making care both available and affordable—is a baseline requirement that brings the patient within the process of care delivery. Once there, the patient has three primary concerns with the quality of care: safety, outcomes, and respect.

The first of these three concerns, safety, has always been part of the healthcare landscape but took on increased prominence in 1999, when the Institute of Medicine released its landmark *To Err Is Human: Building a Safer Health System* report. Many providers now have adopted process metrics and patient safety checklists in an ongoing effort to reduce preventable medical errors.⁸ But even though safety is an essential component of the quality of care, it does not sufficiently define it. Safety is something patients assume when they enter a provider setting; it is equivalent to the “defect rate” in industrial manufacturing, but because it directly affects human lives, it has higher stakes. Just as no one expects to pay for a defective product, no one expects to pay for care that causes harm.

The industry has begun to take steps toward an outcome-based definition of quality. The current metrics on mortality and readmissions following inpatient admissions are early examples. But neither mortality nor preventable readmission is something that patients expect from care. Instead, they are interested in functional outcomes: How soon will I be able to walk or drive a car? When will I be able to return to work? It may take weeks or months of the patient’s treatment to report such functional outcomes, meaning that accountability for quality of care must spread across the care continuum. Moreover, these outcomes will depend on such factors as the patient’s age, general health, or comorbidities. Adding further complication, providers must have functional ways to define outcomes that are both measurable and manageable.

The last remaining concern—respect for the patient’s needs—comprises several elements. Respect involves asking patients about their hopes and expectations for care, including open conversations about care alternatives and the attendant costs and benefits that will enable patients to make decisions about the level of care that is best for them. And it means respecting such fundamental patient needs as privacy, comfort, convenience of care, and security. Care delivery that respects the patient in these ways should lead to higher patient satisfaction. At the same time, a clear understanding of what the patient wants may help avoid costs for care that the patient would prefer not to receive.

Other Purchaser Concerns

Although the patient is at the center of the value equation’s quality numerator, the concerns of employers, government agencies, and health plans will inevitably influence the definition of quality. Even though the concerns of patients and these other purchasers will overlap significantly, there may be some important differences system stakeholders will need to reconcile.

To the extent that health insurance benefits retain and attract talented employees, employers will want to ensure that the plan they offer satisfies employee expectations for access to care. Government programs will also care about access, especially for Medicare beneficiaries in the politically powerful age-65-and-older demographic. Employers and government purchasers may, however, be more willing

⁸ Note, however, that a recent study in *Health Affairs* indicates that several commonly used measures of patient safety miss many adverse events and that adverse event rates at many hospitals—even those that have focused on safety initiatives—remain high. David C. Classen et al., “Global Trigger Tool’ Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured,” *Health Affairs*, vol. 30, no. 4 (April 2011): 581-589.

than patients to consider tiered access programs, in which preventive, acute, and other medically necessary care is widely accessible and affordable but elective procedures are less so. Gaps between patient and purchaser expectations for access are already appearing, for example, in state Medicaid programs, where efforts to contain the impact of Medicaid payments on strapped state budgets are leading state legislatures to consider controls on access to certain high-cost services.⁹

There will be little difference between patients and other purchasers with respect to patient safety concerns. In the area of outcomes, purchaser concerns are also likely to be closely aligned, although the concerns of employer purchasers will focus primarily on cost and workforce productivity. Employer and government purchasers are also likely to support engagement efforts that help patients make better informed choices about their care, especially where these efforts help patients avoid care that is unlikely to produce significant positive outcomes. For government purchasers, however, this is a potentially sensitive area, as demonstrated by the political debates over voluntary end-of-life counseling when shaping implementation of the Affordable Care Act.

The key to quality, then, will involve the creation of meaningful, measurable standards that address patient concerns for care, while balancing the related concerns of other purchasers. This will not be an easy process, and it will require the ongoing collaboration of providers, patients, government agencies, employers, and health plans.

Hospitals and health systems may well want to initiate the process of developing meaningful quality and cost of care metrics instead of waiting to have such metrics imposed on them through government regulation or employer or health plan demands. First, as accountability for care begins to reach beyond the hospital walls, the long-term outcomes of care will have increasingly significant financial implications. Providers who are attuned to metrics indicative of a procedure's or treatment's success will be much more confident in their ability to predict long-term financial outcomes. Second, providers who are able to speak clearly and convincingly to patients and other purchasers of care with meaningful data related to quality outcomes and the price of care will be better positioned to compete for purchasers' healthcare dollars. And third, provider-defined metrics that are linked to measurable quality and cost improvements could play a significant role in shaping industry standards.¹⁰

⁹ The Arizona state legislature, for example, eliminated certain organ transplant services from Medicaid eligibility in the state's FY11 budget, although those cuts were subsequently restored.

¹⁰ For example, six health systems (Cleveland Clinic, Dartmouth-Hitchcock, Denver Health, Geisinger Health System, Intermountain Healthcare, and Mayo Clinic) recently announced a collaboration with the Dartmouth Institute to gather data and share information on outcomes, quality, and costs for a range of common conditions and treatments.

THE CURRENT STATE OF VALUE IN HEALTH CARE

A recognition that the current healthcare system is unsustainable is driving the turn to value. The Congressional Budget Office projects that government spending on Medicare, Medicaid, and other federal healthcare-related programs subject to mandatory spending will more than double from a combined \$870 billion in 2011 to \$1.8 trillion in 2021, growing from a combined 5.8 percent to 7.4 percent of GDP over the same period.¹¹ From 1999 to 2010, premiums for employer-sponsored health insurance grew a cumulative 138 percent, compared with cumulative wage growth of 42 percent over the same period.¹² But there is little evidence that increased spending is being matched with increases in the quality of care.¹³

As noted earlier in this report, there are many problems with the system today. Payment is fragmented among the various purchasers of care, making it difficult for patients to make informed choices based on the actual price of care. Quality data, from the patient's perspective, is often not meaningful and is incomplete, with little information available to compare expected functional outcomes among providers. But the main culprit for the current system's ills is the fee-for-service payment system, which rewards volume over value and does nothing to promote the coordination of care among providers. The first step in correcting the system is a transition from volume-based to value-based methods of payment, and that transition is already under way.

PAYMENT TRENDS

In late 2008, CMS stopped reimbursing healthcare providers for “never events”—serious adverse events that should never occur or are reasonably preventable through adherence to evidence-based guidelines. Since then, CMS has continued to signal its intention to become “a prudent purchaser of health care services, paying not just for quantity of services but also for quality,”¹⁴ and several provisions in the Affordable Care Act support this intention. Beginning in October 2012, CMS's value-based purchasing program will provide incentives to hospitals that exceed certain quality measures relating to clinical care processes and patient experience, while hospitals that fall short on these measures compared with their peers will receive reduced payments. The Affordable Care Act also provides for the creation of accountable care organizations (ACOs) that will participate in shared savings programs for the management of Medicare beneficiary populations, with implementation beginning in January 2012. In addition, it calls for a national bundled payment pilot program for 10 conditions, in which hospitals, physicians, and other members of the provider “team” would receive a global payment for an episode of care, with implementation beginning in January 2013.

On the private side, the not-for-profit PROMETHEUS Payment[®] program is working with coalitions of providers and payers (both health plans and employer coalitions)

¹¹ Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2011 to 2021* (January 2011)

¹² Kaiser Family Foundation, *Employer Health Insurance Costs and Worker Compensation* (February 2011) at <http://www.kff.org/insurance/snapshot/Employer-Health-Insurance-Costs-and-Worker-Compensation.cfm>

¹³ See, for example, Laura Yasaitis et al., “Hospital Quality and Intensity of Spending: Is There an Association?”, *Health Affairs*, vol. 24, no. 4 (July 2009): 566-572.

¹⁴ CMS, “Fiscal Year 2009 Quality Measure Reporting for 2010 Payment Update” (Sept. 3, 2010)

to test a bundled payment system based on “evidence-informed case rates” for selected chronic conditions and inpatient and outpatient procedures. Similarly, experiments such as Blue Cross Blue Shield of Massachusetts’ Alternative Quality Contract, which combines global health-adjusted payments per patient with performance incentives for high-quality care, seek to promote provider accountability for managing the quality and cost of patient care.¹⁵

VALUE-DRIVING CAPABILITIES

Providers are also preparing for a shift from volume-based to value-based care. Research for the Value Project has included surveys of the industry on the current state of value in health care and interviews with providers that are actively working to make a transition to value. This research has identified four key areas of emphasis in which providers are working to build their capabilities.

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

In the discussion that follows, highlights from the provider interviews and results from the current state survey are combined to illustrate the state of the industry today in relation to these four capabilities and the essential skills that will be needed to further advance value transformation.

¹⁵ See Michael E. Chernew et al., “Private-Payer Innovation in Massachusetts: The ‘Alternative Quality Contract,’” *Health Affairs*, v. 30, no. 1 (January 2011): 51–61.

THE CURRENT STATE OF VALUE IN HEALTH CARE

PEOPLE AND CULTURE

The pursuit of value in health care will require new levels of interdisciplinary collaboration, new levels of accountability for results, a new focus on driving process improvement throughout provider organizations, and an ability to communicate the value of a provider’s care to the community it serves. At a foundational level, providers should have the skills to perform the following:

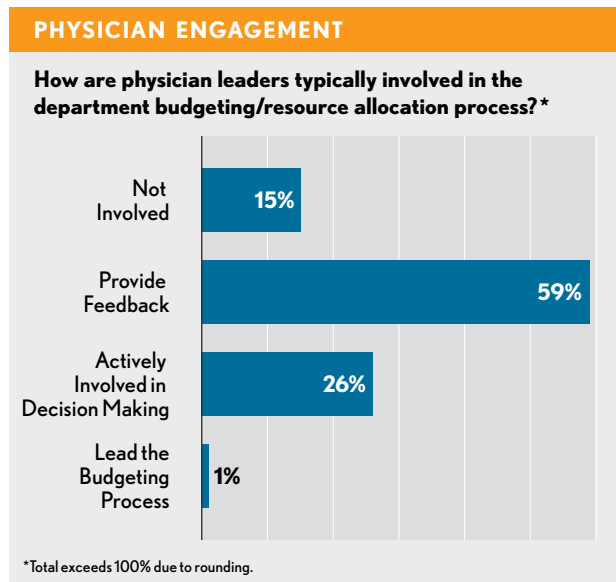
- Define the role of value in the organization’s strategic mission and communicate value to both internal and external stakeholders
- Create engaged, integrated, multidisciplinary teams able to plan and implement process change
- Identify and effectively respond to patients’ concerns or issues that might affect their experience or safety

STATE OF THE INDUSTRY TODAY

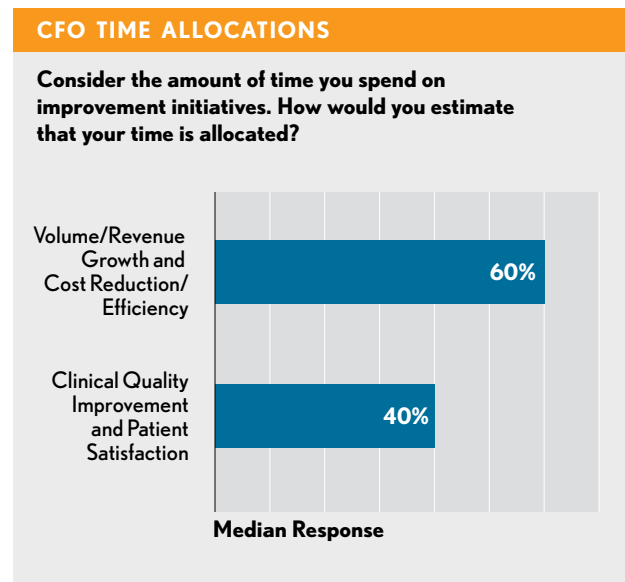
The creation of value requires the participation of clinicians as well as finance and administrative staff. Each needs to pay attention to and respect the concerns of the other. Clinicians, in other words, must be conscious of the cost implications of the choices they make, while finance and administrative professionals must realize that quality outcomes are at least as important as cost efficiencies and reductions.

HFMA’s industry survey on the current state of value indicates that organizations are engaging physicians in key decision-making processes affecting costs, although most do not currently engage physicians as full partners in management. Using involvement of physicians in key budgeting and resource allocation decisions as an indicator of physician engagement at the management level, HFMA found that physician leaders had no involvement at only 15 percent of the respondent organizations. At 59 percent of the organizations, physicians provide feedback on budget and resource allocation decisions, and at 27 percent, physicians lead or are actively involved in decision making—a good sign that physicians have been well integrated into management decisions.

On the finance and administrative side, HFMA’s survey on the current state of value indicates that CFOs spend the majority of their time in more traditional roles, emphasizing cost reduction, efficiency improvement, and volume and revenue growth. But a substantial portion of a CFO’s time today is also dedicated to initiatives related to clinical quality improvement and patient satisfaction. HFMA found that a median 40 percent of a CFO’s time spent on improvement initiatives is dedicated to clinical quality improvement and patient satisfaction.



Source: HFMA Value Project Survey, January 2011.



Source: HFMA Value Project Survey, January 2011.

While these results indicate that CFOs are typically devoting less time to quality and patient satisfaction than to volume or revenue growth and cost-effectiveness initiatives, the amount of time that CFOs already devote to quality improvement and patient satisfaction shows promise. “I’m encouraged by these results. It’s a good start in the direction that CFOs will need to go,” says Peter DeAngelis, Jr., FHFMA, CPA, COO of Catholic Health East in Newtown Square, Pa., and an HFMA Value Advisory Council member.

ESSENTIAL PEOPLE AND CULTURE SKILLS

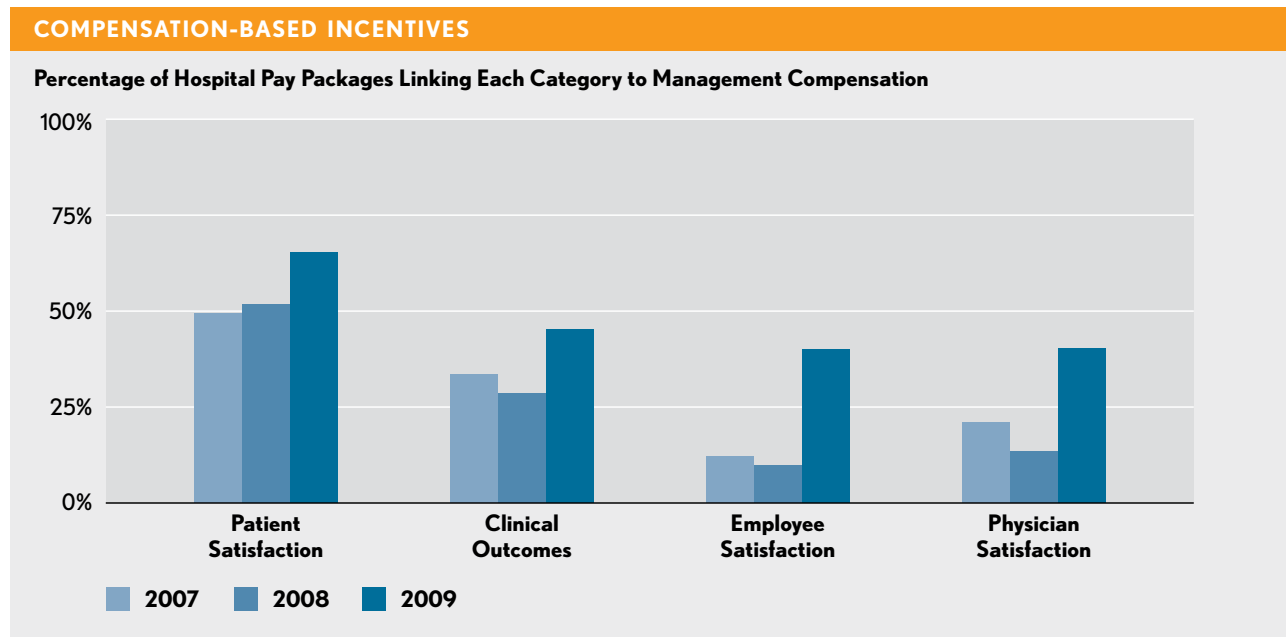
A prerequisite to developing value-based people and culture is the full commitment of the organization’s executive leadership and board to guiding the organization through the changes that a value-based system will require. Building on this foundation requires two essential skills: First is the ability to clearly and concisely articulate to internal and external stakeholders the role that value plays in the organization’s strategy. Next is the ability to promote multidisciplinary collaboration while defining the specific roles that key clinicians—physicians and nurses—and finance and administrative professionals play in the creation of value. As such, providers should consider the following experiences of peers in communicating their value message and how these organizations’ methods for including both clinical and financial

representatives facilitates process improvement and safer, more patient-centered care.

Communicating the Value Message

A first step in communicating an organization’s value message is distilling that message down to a clear, concise statement that communicates the organization’s need for value in a compelling way. Novant Health, based in Winston-Salem, N.C., looked at the value equation through the perspective of its patients and realized that affordability of care was a significant concern. It also looked at payment trends and determined that the direction is toward Medicare levels of reimbursement. It combined these perspectives into a simple statement for staff: The system’s goal would be “affordability at Medicare levels.”

Many organizations also communicate the importance of value internally by linking compensation structures to quality and culture. Sullivan & Cotter’s survey of executive compensation in not-for-profit hospitals and health systems indicates that interest in compensation-based incentives related to value is growing significantly (see exhibit below). In 2009, 66 percent of hospitals tied management compensation to patient satisfaction metrics, and almost 50 percent linked compensation to clinical outcome metrics. Following close behind were links to metrics for employee and physician satisfaction.



Source: Sullivan & Cotter, Survey of Executive Compensation in Hospitals and Health Systems (2007-2009). Adapted with permission.

Nonfinancial incentives can also play a significant role in communicating the value message internally. Spectrum Health in Grand Rapids, Mich., hosts an annual Synergy Awards program, now in its fifth year. Teams from within the health system compete for the awards within such categories as sustainability, innovation, and care improvement, and their entries are scored against a grid that aligns with key organizational goals. Miami-based Baptist Health South Florida has taken a similar approach, hosting an annual Performance Improvement Showcase event to award entities that have been recognized for top performance improvement efforts within the system. Abstracts of the work the entities are doing are collected and distributed throughout the system to facilitate knowledge sharing.

Advocate Physician Partners, a joint venture between physicians and Advocate Health Care, based in Oak Brook, Ill., addresses both internal and external stakeholders with its annual Value Report. The report highlights the organization's clinical integration efforts and quantifies these efforts in terms of patient lives affected and saved, as well as economic impacts and cost savings.

As an example, Advocate Physician Partners' 2011 Value Report highlights the organization's Asthma Outcomes initiative. The report identifies a tool it uses to objectively assess asthma control levels, describes a study that establishes the national average control rate, outlines the components of an asthma action plan that all the members of Advocate Physician Partners are asked to implement, and highlights the organization's achievement of an 88 percent control rate for patients with asthma (38 percentage points above the national control). Drawing on statistics on the economic and medical impact of asthma, the Value Report quantifies the effect of the Asthma Outcomes initiative in terms of days saved from reduced absenteeism (58 days), lost productivity (436 days), and amounts saved in direct and indirect medical costs (\$13 million). The 2011 Value Report describes similar outcomes and impacts for a generic prescribing initiative, a diabetes care initiative, a postpartum depression screening initiative, and a childhood immunization initiative.

The Value Reports published by Advocate Physician Partners accomplish several communication goals: recognition and affirmation of the work of the organization's

clinicians; promotion of value to patients, employers, government entities, and health plans; and emphasis on leadership's commitment to creating and improving value.

Engaging Clinicians in Value

A clear finding from the Value Project interviews is that value cannot be created without the engagement and leadership of clinicians: both physicians, who drive most of the decisions affecting quality and cost of care, and nurses, who are on the frontline of the patient experience and are often best situated to identify and respond to issues affecting the patient and care delivery.

Physicians. Many healthcare organizations are considering an employment model to increase physician alignment and engagement with organizational goals. But an employment model is not feasible or desirable in all markets. The Advocate Physician Partners joint venture with Advocate Health Care, which today includes approximately 3,800 physicians, 2,900 of whom are independent, represents an innovative approach to physician engagement outside the employment model. The joint venture was set up with a shared governance model, with two classes of directors—one from the system side and one from the physician side—represented on the board. Through the joint venture's Clinical Integration program, Advocate Physician Partners and 10 Advocate Health Care hospitals employ structured and ongoing collaboration to improve the quality and efficiency of health care.

A key feature of the program is its pay-for-performance incentive system. Advocate Physician Partners researches metrics and establishes performance targets for each of the program's clinical initiatives, based on national best practices, research findings, and other recognized benchmarks.¹⁶ Physician performance on each of these metrics is monitored throughout the year and reported to physicians quarterly. An incentive plan links the performance of hospital administrators and physicians as a means to increase levels of collaboration and coordination of care. Also, the incentive plan is structured to reward both the individual physician and the physician's peer group, helping to develop a shared culture of excellence and accountability. Physicians are awarded points based on their achievement of quality metrics, and physician bonus payments are based on the number of points earned.

¹⁶ A selection of the metrics used for Advocate Physician Partners' initiatives is available in Advocate's Value Report at www.advocatehealth.com/valuereport.

Because physicians are involved in all phases of development and decision making for the performance metrics, physician buy-in with the metrics is high. Nonfinancial incentives—including recognition of high-scoring physicians and competition between medical groups—have also increased physician engagement.

The specific details of Advocate’s model yield several general lessons for physician engagement at any organization. First, physicians must be represented at a decision-making level across all levels of the organization—from governance down to the unit level. Second, metrics generated with the participation of physicians will ensure the greatest physician buy-in. And third, giving physicians a stake in the outcomes of process improvement initiatives matters, whether that stake takes the form of a financial or nonfinancial incentive.

Nurses. Arizona-based Scottsdale Health System has a strong shared governance program with its nursing staff. If department metrics are not where they should be, then the system will provide nursing staff with the support needed. At the same time, nursing staff understand that they will be accountable for improving the metrics. One example of this shared sense of accountability and commitment can be seen when system leadership identified an increase in pressure ulcer rates at one of the facilities. Two nurses traced it to a defect in mattresses affecting 600 patient beds that were then replaced at no charge by the vendor. Since the discovery, the pressure ulcer rate has decreased to zero in the intensive care unit.

The presence of nursing experience and expertise on process improvement initiatives—again, starting at the top and going down to the unit level—is a common factor among most of the providers interviewed for the Value Project. Peter Markell, CPA, CFO of Partners HealthCare in Boston, Mass., notes that many hospitals have adopted Lean methodologies, derived from Toyota’s production practices. “Under the Toyota model, you let people on the floor make decisions,” he says. “Nurses are the people on the floor.”

Engaging Finance and Administrative Staff in Value

Engaged clinicians are essential to value creation, but so are engaged finance and administrative professionals.

“The CFO needs to be glued at the hip with the quality officer,” says David Bernard, vice president of finance, The Methodist Hospital System, Houston, Texas. “Revenue depends on quality.”

Many of the CFOs interviewed for the Value Project note that engagement with quality requires a change in mind-set for the finance executive. “Not putting an initial focus on cost was something that required a leap of faith on my part, but I’m now a believer in this approach,” says Kathy Arbuckle, CPA, CFO of Marriottsville, Md.-based Bon Secours Health System. Clinicians are engaged by quality and service improvements for the patient; any resulting cost reductions become a natural outcome as variability in clinical processes is reduced and inefficiencies in care delivery are identified and removed.

Bon Secours has also developed a “dyad” model of leadership—combining finance and administrative staff with physicians and nurses—for its Clinical Transformation program. The model extends from the system’s senior leadership team down to teams at local hospitals that together “walk the line” by following patients through the care process to identify safety and waste issues. The team then works together to resolve the issues of care delivery and unnecessary cost identified.

Bringing finance and administrative professionals together with clinicians in an ongoing collaborative process supports process improvement and a patient-centered focus. When commenting on the ingredients for organizational success, Joseph Fifer, FHFMA, vice president of finance for Spectrum Health’s hospital group, points to the importance of a strong working relationship among the executive team—including finance and administrative officers, the chief medical officer, and the chief nursing officer. “Sincere, mutual respect for each others’ disciplines is an absolute necessity,” says Fifer. “You have to manage with knowledge of what’s going on at the bedside, as well as what’s going on at the bottom line. For finance executives, this means getting out of the office to round with the chief nursing officer or sit in on physician meetings. These activities matter; you have to want to know about them. Once that culture of mutual respect has been established at the top, it cascades down throughout the organization.”

THE CURRENT STATE OF VALUE IN HEALTH CARE BUSINESS INTELLIGENCE

For providers to deliver value in health care, they must have accurate, actionable data on the two elements driving the value equation: quality of the care delivered and cost of providing care (the basis for the price that purchasers should be asked to pay for care). They must also be able to link quality and financial metrics to quantify the value of care provided. To build this business intelligence, organizations must have skills to perform several functions:

- Accurately and consistently report data on appropriate metrics developed in collaboration with clinicians
- Drive information sharing throughout the organization by linking department-level dashboards and individual measures to strategic goals and executive dashboards
- Report quality results against core measures

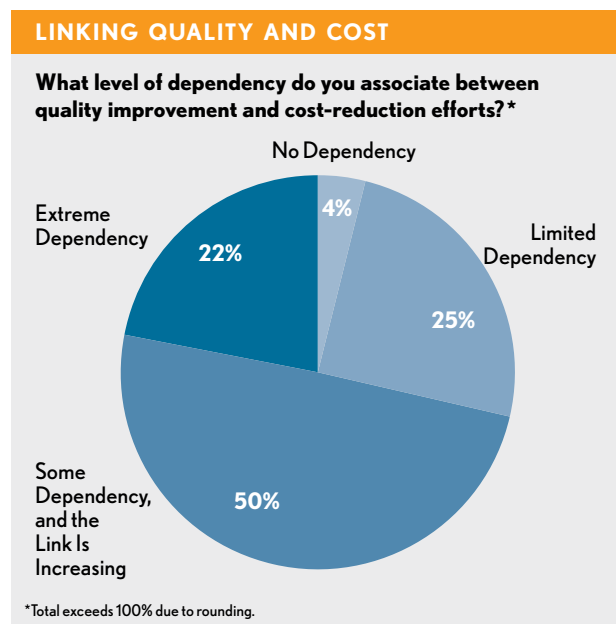
STATE OF THE INDUSTRY TODAY

HFMA's survey on the current state of value indicates that many providers, while recognizing the significance of the link between quality improvement and cost-reduction efforts, are just starting to measure the impact of poor quality and waste on their organizations, and similarly, are just beginning to move beyond traditional methods of cost accounting.

As noted in the exhibit at lower left, fewer than one-third of respondents believe there is no or limited dependency between quality improvement and cost-reduction efforts. One-half of respondents believe there is some dependency, and the link is increasing. Almost one-quarter believe there is extreme mutual dependency.

While more than half of respondents have begun measuring the costs of adverse events and the margin impact of readmissions, only 20 percent of respondents report that they actively manage to these measures (i.e., use the data to drive actions that reduce costs or improve margin). What's more, half of respondents have begun measuring or managing to the cost of waste in care processes, such as duplicative or unnecessary tests or procedures.

The majority of respondents use traditional costing methods, with 69 percent reporting use of ratio of cost-to-charges. In contrast, only 30 percent report use of activity-based costing, which provides a more accurate assignment of both direct and indirect costs to hospital procedures and services. This differential narrows, however, for larger facilities (500 beds or more). Fifty-eight percent of larger facility respondents use ratio of cost-to-charges, but 50 percent of these respondents also use activity-based



Source: HFMA Value Project Survey, January 2011.

MEASUREMENT AND USE OF BUSINESS INTELLIGENCE

To what extent does your organization measure and utilize business intelligence related to value in the following areas?

	Not	Measure	Manage
Costs of Adverse Events	43%	37%	20%
Margin Impact of Readmissions	38%	42%	20%
Cost of Waste in Care Processes (i.e. duplicative/unnecessary tests or procedures)	50%	29%	21%

Not We do not measure.
Measure We have measured the impact, but do not manage to the metrics.
Manage We manage to these measures (e.g. data drives actions to reduce costs or improve margin).

Source: HFMA Value Project Survey, January 2011.

costing (note that respondents to this survey question were asked to select all costing methods used in their organization). Moreover, 79 percent of larger facility respondents report use of a specialized cost accounting system, as compared with 39 percent of the overall respondents.

ESSENTIAL BUSINESS INTELLIGENCE SKILLS

The need for better business intelligence is both recognized and real. Many of the providers interviewed for the Value Project readily acknowledge the inadequacies of their current systems, but they are working to enhance their skills with using data and to develop the systems that will lay the foundation to succeed under value-based payment.

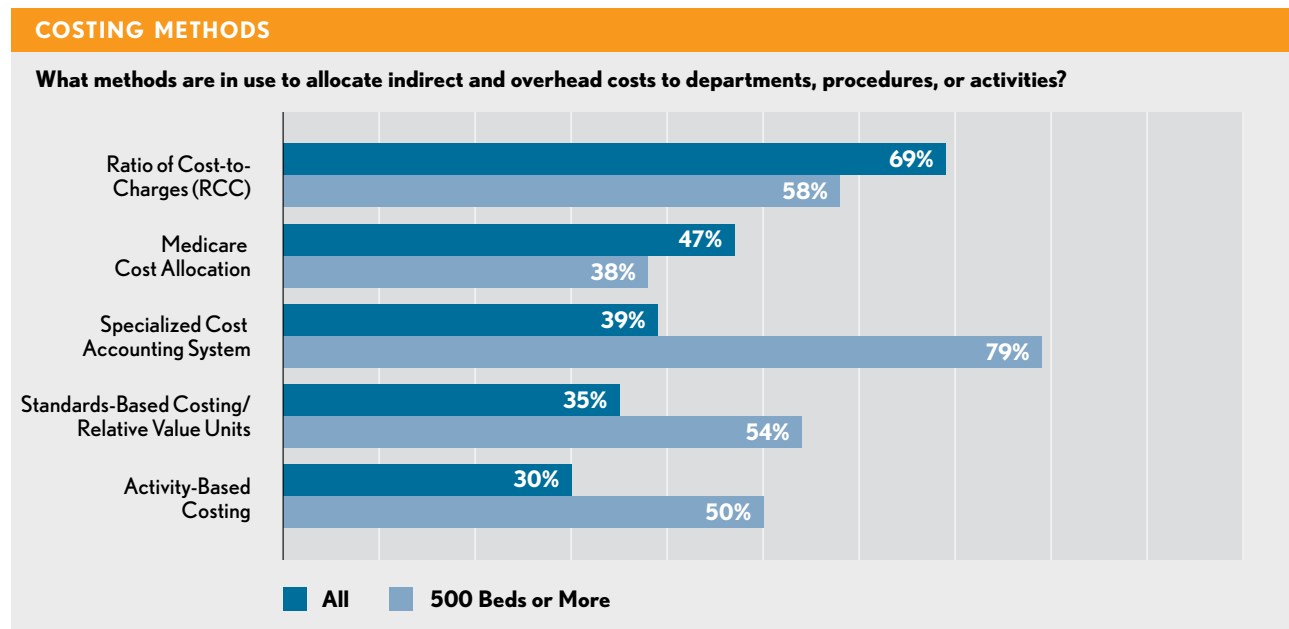
Ensuring Accuracy and Consistency of Data

A small group of providers—including Intermountain Healthcare, Geisinger Health System, and the Cleveland Clinic—represent the vanguard of business intelligence in health care. Intermountain, for example, has already spent decades customizing its business intelligence system to its changing needs. Its first system, introduced in 1960, used automation to improve decisions by, for example, screening for possible interactions during drug entry or recommending antibiotics and associated dosage schedule based on the patient’s medical history. The latest iteration of its business intelligence system—the Enterprise Clinical Information

System, currently in implementation stage—is a system-wide electronic medical record that offers real-time patient views aggregating patient data from all system visits, provides access to best-practice clinical workflow protocols, and uses clinical information to develop granular and longitudinal costing estimates for patient care.

Few organizations, of course, have the expertise or resources to develop their own custom business intelligence systems, but many of the providers interviewed for the Value Project are building business intelligence capabilities—especially in the area of quality improvement—using available software and tools. Bellin Health in Green Bay, Wis., uses a commercially available software program to identify statistically significant variations in care delivery that offer significant opportunities for improvement. Baylor Health Care System in Dallas, Texas, uses the Institute for Healthcare Improvement’s Global Trigger Tool to monitor and characterize the nature of adverse events within system facilities. Hospital teams review the data regularly to direct quality initiatives based on patterns of events and preventability.

In comparison with investments in business intelligence for quality, investments in business intelligence on the finance side have lagged behind. As a result, tying cost implications to performance on quality metrics often requires a good deal of time-consuming, manual work.



Source: HFMA Value Project Survey, January 2011.

Providers also struggle to quantify precisely the financial impact of quality initiatives, although many of the Value Project interviewees note that the effects of quality initiatives on metrics such as length of stay and other indirect macro indicators provide some demonstration when initiatives are working to reduce costs.

A key point is that less than perfect data should not stop a provider from pursuing value. “We need direction, not perfection, from the data,” says Phyllis Lantos, FHFMA, CFO of New York–Presbyterian Healthcare System. “As an industry, we have so far to go. Data use is a tool, not the answer, in improving value.”

A second point is that, although data use may be less than perfect, it needs to be used with the greatest consistency possible. This consideration is especially important when working with physicians, who are data-driven and quick to question the credibility of the information they are asked to work with in improving the value of patient care. Spectrum Health wanted to use clinical improvement projects to improve outcomes for high-volume surgical procedures and medical conditions, but it realized clinicians had little faith in existing metrics and little consensus on the proper metrics. It formed collaborative teams of clinicians and finance staff to develop actionable data for these procedures and conditions. The teams identified mutually agreed-upon metrics and defined how the metrics would be calculated, collaboratively determined the proper source of the data, and established a formal vetting process for the data. As a result of these efforts, Spectrum has been able to actively drive down complication and mortality rates for its high-volume conditions and procedures, positioning itself to take advantage of \$23 million in pay-for-performance incentives under contracts with two managed care providers.

Sharing Information Across the Organization

For business intelligence to be actionable and effective, organizations must ensure that the right information is getting to the right users. At the same time, users need to be able to understand the significance of the information they are receiving within the broader context of organizational strategic goals.

Several of the organizations interviewed for the Value Project have focused their balanced scorecards on a core

set of organizational goals. Sharp HealthCare’s leadership, for example, felt it had reached a point where too many metrics and targets were being measured and decided to bring focus to the organization by defining the “Sharp Experience” around six pillars: quality, service, people, finance, growth, and community.¹⁷ All of the organization’s strategic initiatives are aligned under these six pillars, and management decisions are communicated to all employees so they understand why the initiatives are in place and how the initiative metrics drive toward the broader system goals.

Bellin Health Systems balances its system-wide scorecard across the fundamental categories of effectiveness, efficiency, engaging others, growth, and teamwork. A cross-functional, interdisciplinary leadership team works with “brand” and unit leaders to translate the system-wide scorecard measures into metrics that cascade down to the individual goals of front-line staff (Bellin’s brands are organizational structures that combine all of the services needed for treatment of a condition or procedure). For example, the system goal of engaging others has a “likelihood of recommending” measure. This is traced at the brand level by the “likelihood of recommending” score from the Bellin Psychiatric Center’s inpatient survey result, at the unit level by the “likelihood of recommending” score for the Bellin Psychiatric Center’s adult unit, and at the individual therapist’s or psychiatrist’s level by scores on individual patient satisfaction surveys.

The alignment of system-wide goals with department-level and individual metrics helps keep the entire organization on track. Staff understand how the information they are gathering and reporting relates to the organization’s overall direction, while management and executive teams can readily see whether the organization is exceeding, meeting, or underperforming on its goals.

Reporting Quality Results Against Core Measures

Changes in Medicare payment—particularly CMS’s new value-based purchasing program—mean that most healthcare organizations will be paying attention to their ability to report on CMS core measures and HCAHPS patient experience of care measures, if they have not already been doing so. Payment under value-based purchasing will be tied to both achievement, which measures a hospital’s performance as compared with other hospitals’

¹⁷ The Sharp Experience pillars resemble the Studer Group’s five pillars of service, quality, financial, people, and growth (see www.studergroup.com), but add a sixth pillar for community.

performance, and improvement, which measures a hospital's improvement on its baseline performance score. For hospital business intelligence systems to be effective under value-based systems, they will need to automate reporting against these core measures in a way that allows users to easily monitor and track progress across the organization, compare performance with internal benchmarks and national averages, and respond to issues as they arise.

Partners HealthCare in Massachusetts has developed a dashboard that tracks internal performance against Massachusetts-area health system averages, national hospital averages, and other selected competitors. The dashboard tracks performance on such metrics as CMS core measures, Leapfrog Group patient safety measures, HCAHPS patient satisfaction survey measures, and HEDIS ambulatory care measures. The dashboard shows green if Partners is performing in the top 10th percentile of its comparison group, yellow if below the top 10th percentile but still above the group average, and red if below the group average.

The Partners dashboard serves several purposes: It demonstrates the organization's commitment to quality above and beyond what is required, it keeps staff focused and engaged in quality improvement, and, through comparisons with specific competitors, it promotes the staff's own competitive drive to be the best.

Business intelligence will likely require the most capital investment of the four value-driving capabilities described in this report, as healthcare organizations build IT systems and acquire software that enable them to track and link performance outcomes and cost data. However, business intelligence also may be the most important of the four capabilities, as it facilitates linking clinicians and staff throughout the organization, produces the data that can verify the outcomes and financial implications of performance improvement efforts, and enables the creation of patient information repositories that will become increasingly important as providers contemplate the assumption of risk.

THE CURRENT STATE OF VALUE IN HEALTH CARE PERFORMANCE IMPROVEMENT

Performance improvement capabilities comprise the skills needed to reduce variability in clinical processes and improve delivery and outcomes of care. To effectively improve performance, providers will need skills to be able to conduct the following:

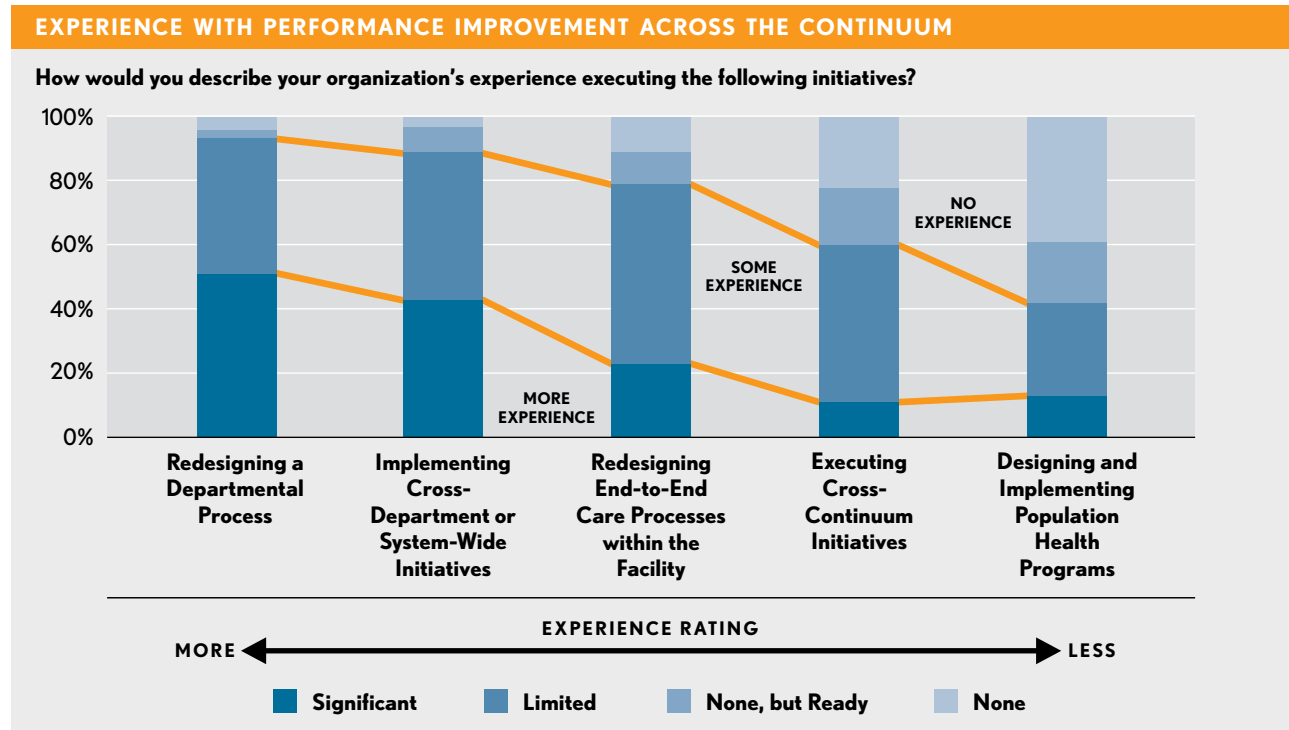
- Identify and prioritize improvement opportunities
- Develop well-defined processes to ensure that clinical redesign projects achieve their defined goals
- Identify and create consensus around evidence-based practices (from both internal and external sources)

STATE OF THE INDUSTRY TODAY

The results of HFMA’s current state survey indicate that more than 90 percent of respondents have at least some experience redesigning clinical processes within a department—with over 50 percent reporting significant experience. Just under 90 percent report significant (43 percent) or some (46 percent) experience implementing cross-department or system-wide initiatives. Experience levels drop off significantly, however, for care redesign that

moves beyond a facility’s walls to a cross-continuum initiative. Just 11 percent of organizations report significant experience with such initiatives, while 48 percent have some experience. Similarly, only 13 percent of respondents report significant experience with designing and implementing population health programs, with providers reporting some experience in this area at 29 percent.

This difference between experience levels for in-facility and cross-continuum initiatives is not surprising. The earliest CMS quality initiatives have focused on patient safety metrics and avoidance of “never events” within the immediate control of a facility. But new initiatives are moving accountability for care beyond a hospital’s walls. A penalty for readmission of a patient within 30 days of a procedure may relate back to the care provided within the hospital, for example, but it may also be the product of post-acute care or a patient’s failure to adhere to a care protocol. As accountability for the longitudinal care outcomes of patients increases, so too will the need for patient engagement and coordination of care across the continuum.



Source: HFMA Value Project Current State Survey, January 2011.

ESSENTIAL PERFORMANCE IMPROVEMENT SKILLS

The organizations interviewed for the Value Project are actively engaged in clinical process redesign focused on reducing the variability of clinical practice patterns and identifying and removing waste from clinical processes. Success of these efforts depends on identifying the right opportunities, ensuring that projects stay on goal, and promoting the development and adoption of evidence-based practices.

Identifying and Prioritizing Improvement Opportunities

In virtually all organizations, opportunities for improving clinical processes outnumber the resources available to implement process redesign, so prioritization of these opportunities is a critical first step.

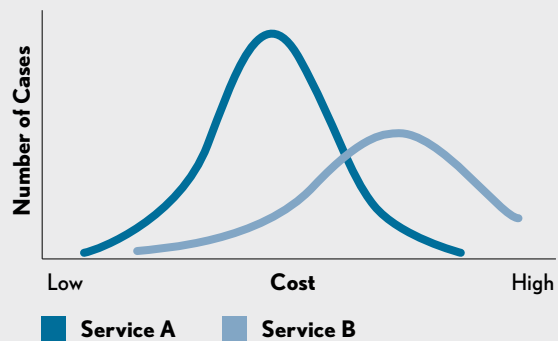
At Rush University Medical Center in Chicago, Ill., the prioritization process begins with examining data to identify quality opportunities where there are higher costs per discharge and greater variation in costs across the practice group. In the exhibit at right, Service B would be a better target for performance improvement because it has higher average costs and greater variation in costs than Service A.

But examination of the data is just a first step. Equally important is identifying and engaging physician groups where there is a willingness to take on change. “Our approach is data-driven, but making a decision on where to start involves a mix of data, gut instinct, and physician engagement,” says Raj Behal, MD, associate chief medical officer at Rush. “You don’t want to start with your toughest cases first.”

At Sharp HealthCare, projects that are considered for implementation must fall under one of the system’s six strategic pillars and must align with the system’s strategy. Qualifying projects are then prioritized through multiple senior leadership meetings where competing priorities are brought to the table, discussed, and ranked. Sharp recognizes that successful implementation depends on the availability of adequate resources, so it limits the number of initiatives under way at any one time, demonstrating the

IDENTIFYING IMPROVEMENT OPPORTUNITIES

Cost Distribution for Clinical Value Bundles



system’s focus and commitment to the initiatives that do make it to implementation. The reasoning behind the senior leadership’s prioritization of projects is communicated to the staff to help mitigate frustration over projects that are not selected.

Once a project has been functional for one year, Sharp performs an assessment to determine how the initiative’s outcomes compare with goals and expectations for the project. If alignment isn’t sufficient between the project’s goals and actual outcomes, the project is stopped so that the system can dedicate resources to other initiatives.

Organizations skilled in identifying and prioritizing performance improvement projects must, in other words, know both when to begin a project and when to end it. Not every project will be a success, and organizations must be ready to redeploy their resources to pursue more promising opportunities.

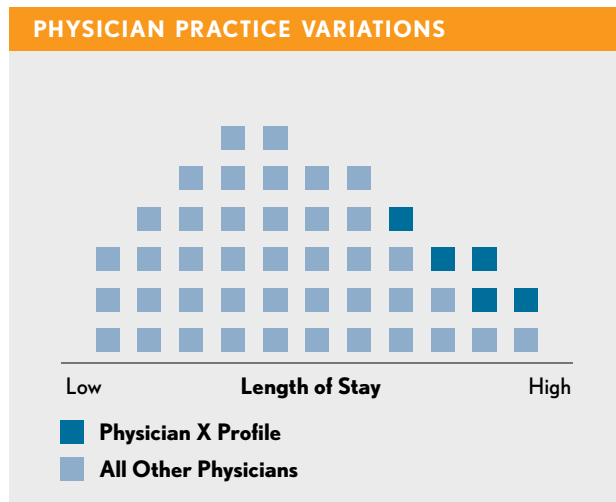
Developing Processes to Ensure Projects Meet Goals

Several of the Value Project interviewees have developed well-defined processes for clinical reengineering initiatives. These processes ensure that initiatives are both viable and kept on track for implementation.

Rush University Medical Center has developed a 12-week rapid cycle improvement process, which begins with prioritization of possible process improvement areas.

The clinical department chair and other physicians within a potential target area are engaged to consider undertaking a process redesign, with the understanding that clinicians will control the elements of the redesigned care protocol. The physicians review data provided by the hospital to identify practice variations among individual physicians, analyze the reasons for these variations, and then define metrics and processes intended to reduce the variations. For example, in the exhibit below, an analysis of physician practice variations in length of stay indicates that Physician X displays higher cost patterns among his peers, and his practice patterns would warrant further analysis and discussion.

Following the development of the fact base and initial metrics for the area, the improvement plan is introduced at a formal kickoff with the clinical resource management steering committee, which is chaired by Rush’s CEO. Physicians, nurses, and pharmacists are brought in for this meeting. The group reviews the initiative’s quality and cost targets as well as potential for growth for the practice area, and it assigns accountability for the initiative goals. Final consideration comes at the end of the 12-week period, when quality and cost targets and metrics have been approved, are aligned with potential growth opportunities, and are adopted as the standard for tracking performance improvement within the area.



The performance plan at Bellin Health is based on the Juran trilogy¹⁸ of quality design, quality control, and quality improvement. *Quality design* focuses on new innovations for performance improvement. Performance improvement initiatives that make it to the system-wide agenda must meet two criteria: They must affect multiple departments, and they must address the system’s three priorities of clinical outcomes, patient satisfaction, and financial viability. *Quality control* focuses on current processes that have gone off target in terms of reliability, predictability, or safety. In the case of both quality design and quality control, innovations or corrective actions follow a 120-day planning and review cycle. During this period, system and initiative leaders monitor and track performance and outcomes and adjust resources toward improvement initiatives that are showing the greatest promise. To support *quality improvement*, processes with proven impact on the advancement of the priorities are incorporated into the system’s balanced scorecard metrics.

For hospitals and health systems to improve quality, they need to ensure that their processes for supporting high performance are able to accommodate and adapt to new knowledge. At the same time, processes with clear parameters and time schedules, such as those employed by Rush and Bellin, keep stakeholders focused and on task.

Creating Consensus Around Evidence-Based Practices

The ability to establish consensus among clinicians around evidence-based practices is critical for both the initial and long-term success of performance improvement efforts. An effective model for building consensus has been developed by Bon Secours Health System as part of its Clinical Transformation initiative.

Performance improvement initiatives are identified and approved at the system’s senior leadership level, and then they are rolled out to local interdisciplinary teams, which include both clinicians and finance and administrative staff at the system’s individual hospitals. The system leadership defines general “guardrails” for the local transformation teams, but the teams are encouraged to experiment with process improvements within these constraints.

¹⁸ Named for 20th-century quality management theorist Joseph M. Juran.

After the local interdisciplinary teams trace the patient experience through the care process to identify practice variations, possible safety issues, and waste in a manner that mirrors industrial process redesign efforts, practicing clinicians on the team are tasked with developing practical care delivery solutions to the problems identified, which helps ensure clinician buy-in.

All of the local teams working on a common initiative meet monthly by phone to share knowledge, discuss problems, and identify emerging “best practices.” Once a best practice is identified and agreed on, it is standardized across the system. An internal audit follows after implementation to ensure that once a process is put in place, it is adhered to across the system.

A best practice might be identified internally, as in the Bon Secours example, or through external research. In either case, the key to consensus-building is a collaborative approach that reflects the input of stakeholders across the system who ultimately will be asked to implement the practice.

The need for collaboration runs throughout the performance improvement capability. Clinicians and administrative staff must partner to identify opportunities for change; create processes and metrics for performance improvement that are actionable, measurable, and sustainable; and promote the adoption of proven practices throughout the organization. Performance improvement cannot be a one-time collaboration; it must represent a continuing, system-wide effort to improve the quality and efficiency of care.

THE CURRENT STATE OF VALUE IN HEALTH CARE

CONTRACT AND RISK MANAGEMENT

For most providers, contract and risk management is probably the capability with which they have the least experience (although they may have had historical experience with capitation during the managed care experiments of the 1980s and 1990s). But as both government agencies and health plans initiate programs piloting various forms of value-based care, from episode-of-care-defined bundled payments to ACOs that assume responsibility for defined patient populations, the need to develop contract- and risk-management capabilities will increase.

Management of care episodes or the delivery of “accountable care” will in many cases require an extension of care across a network of providers. Providers will need to develop capabilities in assessing the potential risks and benefits of acquiring other providers or engaging with them contractually to build a care network. Considerations will include how to divide the care services, accountability for outcomes, and revenue among network members. Also, providers will need to predict and manage different forms of patient-related risk under different payment methodologies. For example, providers will need to evaluate performance risk for patient outcomes under an episodic or bundled payment system for acute-care procedures, or they will need to understand utilization risk under a bundled payment system for chronic disease management or a per-member-per-month capitated payment system.

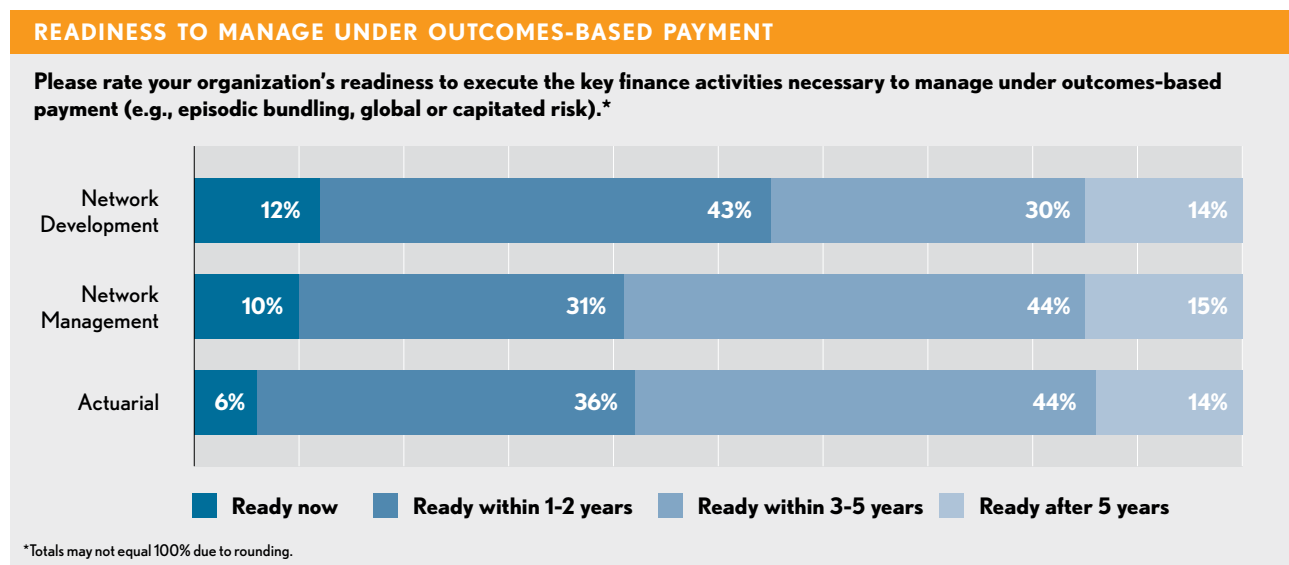
In the near term, providers will need skills to perform the following:

- Create partnerships with payers to meet mutual needs, collaborate on payment system evolutions, and discuss progress toward quality and cost goals
- Develop cross-functional collaboration among clinical, finance, and contracting departments to ensure that agreements can be successfully implemented and managed
- Effectively manage utilization among the organization’s patient population, ensuring that the right care is provided at the right time at the right location

STATE OF THE INDUSTRY TODAY

The results of the HFMA current state survey show that very few providers are ready to take on the network development, network management, and actuarial activities that will be necessary under value-based payment methods that involve episodic bundling, partial capitation, or global risk. Only 12 percent of providers say they are ready now to take on network development. Slightly fewer—10 percent—are prepared today for network management, and just 6 percent are ready today to engage in actuarial activities. Many, however, anticipate readiness within the next five years.

The need for contract- and risk-management capabilities is emerging quickly, however, as public and private



Source: HFMA Value Project Survey, January 2011.

purchasers of care move forward with new payment models. CMS's new proposed regulations for ACOs, for example, offer one model under which providers would accept risk for their ACO population immediately ("track two" ACOs); under the second available model ("track one" ACOs), providers would have to accept risk after two years. Private purchasers and health plans are already actively negotiating with willing providers on models that involve greater performance risk and shared savings. And in some areas of the country, especially the West Coast, capitation has never gone away.

ESSENTIAL CONTRACT- AND RISK-MANAGEMENT SKILLS

Few of the providers interviewed for the Value Project have exposure today to payment methods that require the strongest skills in contract and risk management. But many have been working on better collaborations with payers, stronger internal collaborations, and improved utilization of their facilities—all important skills for successful contract and risk management.

Creating Partnerships with Payers

San Diego-based Sharp HealthCare receives over one-third of its revenue under capitation and has managed capitated payments for the past 25 years. Stacey Hrountas, Sharp's vice president, managed care, has this advice for any provider considering a capitated payment arrangement: "Get a commitment from your payer partners to look at the arrangement as a collaboration, not a negotiation. They must be willing to meet with you frequently and tweak and adjust the arrangement as you go."

Minnesota-based Fairview Health Services and Medica Health Plans are developing this sort of provider-payer collaboration to transition from fee-for-service payment to a shared savings model and, ultimately, population health management. They have developed this list of principles for commercial payers and providers in a value-based world:

- Shared commitment to create value
- Shared commitment to multi-year partnerships
- Focus on population health and the engagement of patients and consumers
- Collaboration on and investment in new care models (both primary and specialty) and defined payment models that recognize the value created

- Sharing of real-time, transparent data and information to drive improvements
- Shared savings models in which providers retain the majority of savings
- Commitment to creativity and innovation
- Dedication to better outcomes and reduced administrative costs
- New products to expand covered lives¹⁹

The principles defined in this list will furnish a collaborative roadmap for Fairview and Medica as they work to implement a payment pilot in which Fairview's guaranteed fee-for-service payments diminish, while its incentives to improve quality and cost of care increase. Creating such an understanding with a payer in advance helps to ensure that both parties agree on the goal and the flexibility that may be needed to achieve it.

Sharp HealthCare also emphasizes that a payer partner must be willing to share historical claims data on the full managed population, especially if—as will usually be the case—the provider organization does not have its own data providing a complete picture of historical utilization. Without access to the full claims history for a population, a provider will not have sufficient information to understand utilization and take measures to positively affect quality or cost of care. Organizations that choose to pursue capitated contracts without this crucial information will expose themselves to substantial financial risk.

Developing Collaborations Among Clinicians, Finance, and Contracting Departments to Ensure Success

Sharp HealthCare emphasizes the importance of having relationships with clinicians to understand variations in cost that may appear in the data. Josh Schmidt, Sharp's director of managed care finance, connects with clinicians daily to get information from specific cases that stand out in his review of data for the system. "The relationships with clinicians are essential to make the numbers actionable," says Schmidt. "Numbers mean nothing without actionable information."

Equally important are relationships between the contracting department and finance. "You need to get agreements that can actually be implemented," says Sharp's Stacey Hrountas. "Finance needs to know what the system is committing to before the agreement is signed."

¹⁹ Presentation of Terry Carroll, PhD, senior vice president for care transformation and CIO, Fairview Health Services, and Charles Fazio, MD, chief medical officer, Medica, at HFMA's *Leadership Conference on Value*, April 1, 2011, Chicago, Ill.

Hrountas also cautions that capitated lines almost always operate best within an environment that has centralized finance, administrative, contracting, and clinical functions, where it is easier for the left hand to know what the right is doing.

Managing Utilization Effectively

Providers who are considering an arrangement involving assumption of risk for a patient population will need to develop two essential skills for utilization management: First, they must ensure that patients are properly utilizing the right facilities for their care needs. Second, they must try to ensure that patients stay within the provider's network when they do need care, so the provider that has assumed the risk of managing the patient's health can make sure that care for the patient is being properly coordinated and delivered.

Adventist HealthCare, a five-hospital healthcare system based in Rockville, Md., assumes the financial risk of providing health care to its employees and their dependents through its own health plan, Adventist HealthNet, a self-funded employee benefit plan. The organization examines and manages factors affecting this risk carefully. As an example, expenditures for the plan rose at a rate of approximately 4.2 percent from 2004 to 2008, but then rose by more than 12 percent in 2009. Analysis revealed that this increase was driven by 454 plan participants whose costs represented 60 percent of the plan's total costs for the year. The system responded with the launch of a pilot patient-centered medical home focused on caring for the needs of what they define as "poly" users—those participants who saw at least 15 providers and had at least nine prescribing physicians within a year—within the group of 454 high-cost participants. The system identified 46 "poly" users to participate in the pilot and assigned eight primary care physicians to manage their care needs. A personal health nurse was also assigned to each of the primary care physicians to develop a personal health plan addressing such items as dietary counseling, baseline screening appointments, or exercise plans for each of the pilot participants and to facilitate the participants' compliance with the plan.

The first year of the pilot showed significant success, with improved overall health of pilot participants, more efficient use of the healthcare system, and reduced costs

per member in the plan. The number of high-risk patients enrolled in the pilot was reduced by 48 percent, a reduction represented largely by patients who were able to move from high-risk to moderate-risk or low-risk categories as a result of improved health. Reductions in overall utilization of the healthcare system led to a 35 percent reduction in per-member-per-month (PMPM) costs for the pilot participants (from \$1,981 in 2009 to \$1,290 in 2010), even as overall PMPM costs for non-pilot plan members increased slightly over the same time period (from \$296 in 2009 to \$299 in 2010).

To help ensure that patients within its capitated population of approximately 279,000 lives are receiving properly coordinated care, Sharp HealthCare has developed a centralized, system-wide department focused exclusively on patient "repatriation," or bringing those patients admitted through out-of-network emergency departments back into the system, where access to their medical record supports better coordination of care and minimizes the likelihood for duplicative tests and procedures. Sharp's repatriation department employs nurse case managers who work with out-of-network providers in the area so they know to contact Sharp if a Sharp patient is admitted to their facility. If the patient is stable for transportation and Sharp has the right bed available for the patient's care, then the patient is brought to the appropriate Sharp facility. If it is not feasible to transport the patient back into the network, Sharp's nurse case managers go out daily to review the patient's care. "Our efforts add up to better care for our patients," says Hrountas. "Families of patients who are in non-Sharp facilities are wowed when Sharp nurses come by to check on their family member's care."

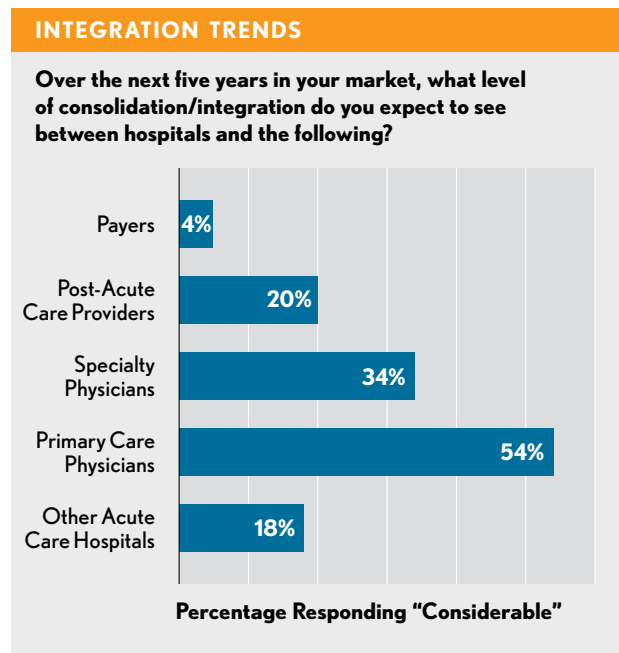
Sharp manages a sizeable capitated population, but providers should not think that development of contract- and risk-management capabilities is contingent upon the return of capitation. Various forms of risk—from performance to utilization—are quickly emerging as part of the new healthcare landscape. Providers can prepare themselves by developing relationships with payers in their market; promoting the collaboration of clinicians, finance, and contracting departments on new payer contracts; and better understanding who their patients are and how they utilize internal services.

THE FUTURE STATE OF VALUE IN HEALTH CARE

The trends toward value-based payment outlined in the current state section of this report are likely to intensify in the future. Looking forward, it is important to understand key assumptions for the future state of health care, industry perspectives on readiness in light of these assumptions, and the types of care models that will be most likely to succeed.

ASSUMPTIONS GOING FORWARD

Payment cuts. Growth of healthcare costs at the current rate will almost certainly lead to government-imposed price controls in the form of slowed payment rate growth or rate reductions. Although providers have historically been able to cost-shift these payment reductions to the private sector, strong resistance to this approach means it will no longer be sustainable.



Source: HFMA Value Project Survey, March 2011.

Increased market demand for value, transparency.

System stakeholders—including patients and consumers, employer and government purchasers, and health plans—will demand greater value for their healthcare dollar, pushing for increases in quality outcomes and cost savings. Greater transparency of quality and pricing information will allow stakeholders to identify and use high-value providers.

Push for innovation. To meet the demand for value, providers will have to innovate with service-line mix and cost structure and consider revenue models that hold them accountable to some degree for performance-based patient outcomes.

Focus on primary care and controlling high-cost acute care utilization. Attention will focus increasingly on healthcare cost “hot spots”—including neonatal intensive care, chronic disease management, and end-of-life care—and on a primary-care led system that controls utilization and coordinates care across the continuum. Although a need for acute care will remain, hospital admissions will in many cases be viewed as a potentially avoidable cost of care.

Shifting risk dynamics. The drive for accountability will increase provider partnerships and integration, and providers will need to develop contracts, manage networks, and absorb risk in the most optimal manner, depending on what role an organization chooses to play in a value-based payment ecosystem.

INDUSTRY PERSPECTIVES ON THE FUTURE STATE OF VALUE

In a survey on the future state of health care, HFMA found that many providers anticipate significant change, even if they have not yet begun preparing for it.

Over half of the survey respondents expect considerable integration between hospitals and primary care physicians over the next five years, and a third also expect considerable integration between hospitals and specialty physicians.

Providers also anticipate that within the next 10 years their payments will be subject to increasing levels of performance risk through value-based payment methodologies such as bundled payments, capitated payments, or shared savings with penalty contracts.

A clear majority of survey respondents anticipate a future need to invest in population health management capabilities; only 17 percent are not planning to invest.

As the exhibit at lower right indicates, many of the providers that see a likely need to invest in population health-management capabilities are planning to wait for clarification on the future direction of payment methodologies. Several of those methodologies—and the care delivery models that might best respond to them—are taking shape now.

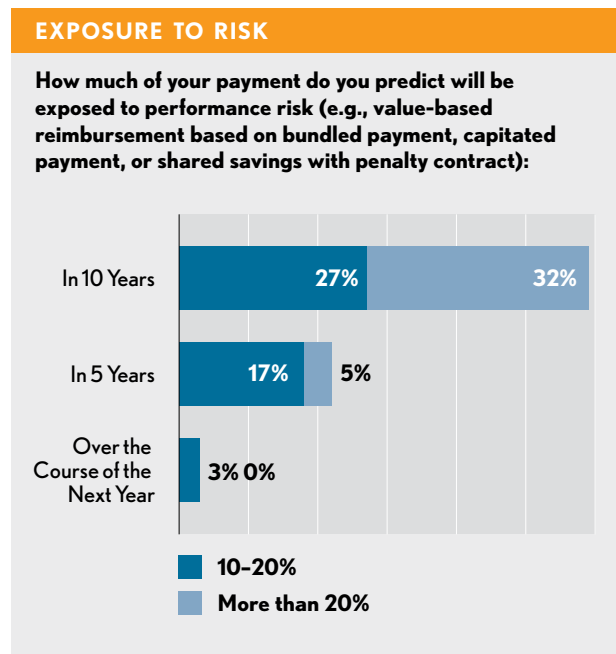
FUTURE CARE DELIVERY MODELS

The capabilities grid on p. 29 illustrates particular skills within the four capabilities of people and culture, business intelligence, performance improvement, and contract and risk management that providers will need to develop to accommodate the demands of different payment methodologies requiring varying levels of provider integration and assumption of risk. As payment methodologies shift to the right side of the grid the need to create integrated networks

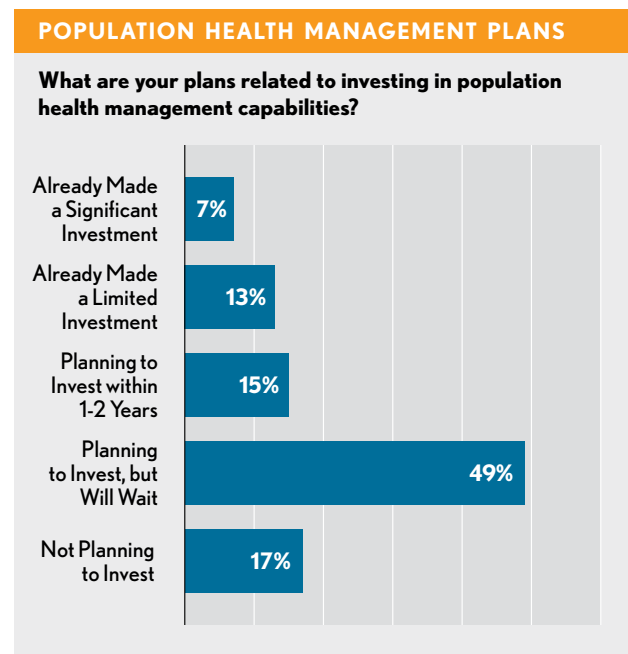
of providers (formal or informal) to coordinate care across the continuum intensifies. Providers also assume more risk as payment methodologies shift to the right. Performance risk emerges almost immediately under a pay-for-performance methodology. Population risk and the attendant need to manage utilization effectively become critical considerations under disease and chronic care management and total health management methodologies.

For the foreseeable future, it is likely that a range of payment methodologies will coexist, although emphasis will shift toward the center and right of the grid. Similarly, a range of strategies will be available to healthcare providers, depending on their desire or need to integrate with other providers and their ability to assume risk. Decisions regarding integration and assumption of risk will be driven by a number of factors:

- Alignment of medical staff
- Sophistication and use of IT for clinical and financial decision making
- Access to human and financial capital
- Market share and competitive environment
- Record of success with performance improvement
- Skills in the medical management needs of the provider's patient population



Source: HFMA Value Project Survey, March 2011.



Source: HFMA Value Project Survey, March 2011.

A provider with strength in all these areas will have considerable flexibility in considering future strategies, but a provider with weakness in any of these areas should carefully consider whether it can survive independently or should pursue a strategy involving integration with a stronger entity.

The range of future state strategies displayed in the exhibit below does not represent an exhaustive list. Instead, it is a highlight of strategies currently taking shape that hold promise for a value-based future state; each of these strategies involves varying degrees of integration and risk assumption.

Price-Taking Providers

Many industries have already gone through a value-based transformation. The retail industry, for example, has been reshaped over the past few decades. The rise of “big box” retailers, focused on generating large sales volumes through a nationwide network of stores, challenged smaller, independent retailers by offering a wider breadth (e.g., Wal-Mart) or depth (e.g., Barnes & Noble) of inventory at lower prices than independent retailers could match. Some of the big box retailers have, in turn, been challenged by the rise of e-commerce. Both Borders and Barnes & Noble have struggled against Amazon’s online business, and the

CAPABILITIES GRID							
← Lower Degree of Risk and Integration Required Higher →							
Organizational Capabilities	Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
People & Culture	Cultural Emphasis	Establishing Learning Organization	Leading with Quality			Managing Long-Term Conditions	Engaging the Community
	Management and Governance	Informal Physician Leadership	Formal Acute-Care Physician Leadership		Communities of Practice		
	Operating Model	Department Structure		Episode-Focused Service Lines		Cross-Continuum Product Lines	Community Collaboratives
	Performance and Compensation	Productivity-Based		Outcomes Based			
Business Intelligence	Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	PMPM	
	Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
	Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
	Decisions Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	
Performance Improvement	Process Engineering	Identifying Service Variability	Increasing Reliability within Clinical Value Bundles		Optimizing Care Pathways Across the Continuum		
	Evidence-Based Medicine	Increasing Patient Safety	Developing Clinical Value Bundles			Managing Conditions	Improving Wellness
	Stakeholder Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	
Contract and Risk Management	Contract Management	Negotiating Pricing	Balancing Cost and Quality Aims		Network Development Funds Distribution		
	Risk Modeling and Management	Profit/Loss Analysis	Estimating Exposure			Predicting Outcomes	

■ Low Degree
 ■ Medium Degree
 ■ High Degree

increasing popularity of e-books further threatens the status of their bricks-and-mortar outlets.

Changes in the retail industry have had a significant impact on independent retailers, which cannot compete on either selection or cost. Many—but not all—have gone out of business. Those that have survived have done so because of other factors, such as quality of service, quality of products offered, or convenience of location, that retain a sufficient customer base to maintain profitability. But success for these retailers requires vigilance: A slip in the quality of service or product offered, the introduction of a new competitor, or too great an increase in the differential between the independent retailer’s prices and those of its larger competitors can erode the customer base.

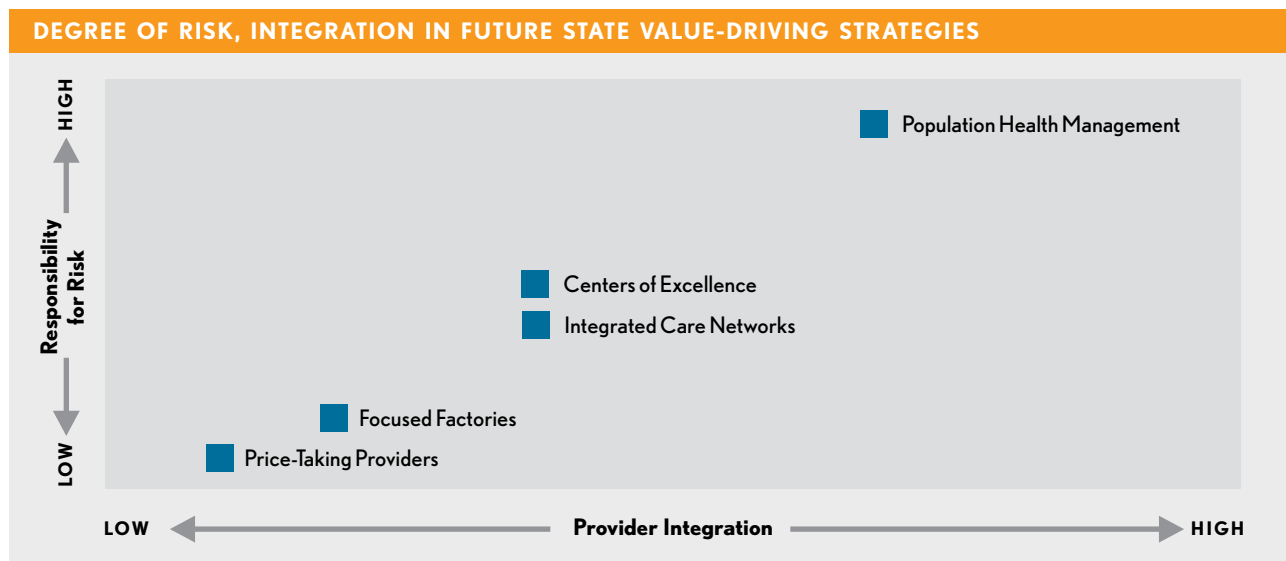
Just as some independent retailers have survived the transformation of retail, some healthcare organizations may be able to adapt to and survive the value transformation of health care relatively unchanged. These organizations will most likely be the dominant provider in their local market. They will need to offer a consistently high level of care for the services offered and do so at prices that are attractive or perhaps fully competitive with the lowest cost providers. These providers will have to maintain a high level of vigilance with respect to both quality and cost. People may prefer to use a local healthcare provider, but quality of life—and sometimes life itself—is at stake with health care. If patients have any reason to doubt the quality or safety of their local care option, many will go elsewhere for their care, especially if they will not have to pay more to do so. Price-taking providers will also face the threat

of competition from new entrants in their market—and, as in retail, these entrants might be virtual or bricks-and-mortar. Price-taking providers will also have to prove continually their value proposition to other purchasers of care—employers, government agencies, and health plans—which will always be looking for better value providers. They will also need to maintain their flexibility, remaining open to alliances that may expand the services they can offer or lower the cost of the care they provide. If the pressures of a value-based system become too great, they may ultimately need to merge with other organizations.

For organizations that prefer to exist as price-taking providers, the following capabilities will be essential.

People and culture. Price-taking providers will have difficulty matching the cost-effectiveness of larger, more integrated networks. Therefore, they will need to focus on leading with quality—including safety and clinical outcomes. Respect for their patients’ comfort and needs—maximizing the patient experience—will also augment these providers’ value proposition.

Business intelligence. Price-taking providers will need to keep their prices as low as possible to minimize the risk of losing patients or being dropped from a health plan’s network, and they will have to accept the price they receive from government programs. As a result, activity-level costing will be necessary to ensure that the prices paid for care generate a sufficient operating margin for the provider. These providers will also need meaningful, comparative data on quality outcomes and patient



satisfaction to communicate their value message to patients and other purchasers.

Performance improvement. Identifying and eliminating service variability will be needed to ensure a constant level of quality for the services provided. Consistent quality and high patient safety will be essential to retain customer loyalty and optimize revenues under Medicare’s value-based purchasing program.

Contract and risk management. Price-taking providers will have little flexibility in negotiations with employers and health plans. They will have to enter negotiations with a clear sense of the patient volumes and prices needed to maintain their viability.

Focused Factories

The “focused factory” strategy in health care has been most fully developed in the work of Harvard Business School professor Regina Herzlinger. In focused factories, providers integrate around treatment of specific conditions or procedures, emphasizing consumer needs regarding the price, efficiency, and convenience of care. Retail clinics, such as CVS Caremark’s MinuteClinics or Walgreens’ Take Care Clinics, are an example of focused factories. They offer a limited menu of services—typically vaccinations, treatment of minor illnesses and injuries, physical examinations, and disease management services (e.g., high blood pressure or blood sugar testing)—with set prices and offer convenient locations and service hours.

Hospitals and health systems are also entering the market with primary care clinics tailored to the needs of employers and patients. Southwest Florida-based Lee Memorial Health System established primary care clinics for its own employees several years ago. In conversations with human resources officers from other industries, the system’s chief human resources officer realized that there was a demand for such services from local employers. Working with the city of Cape Coral, one of the largest local employers, Lee Memorial developed primary care clinics that are run out of four of the system’s hospitals. The clinics offer a limited menu of primary care services, such as flu shots, treatments for cold and flu, and blood pressure screening, that was developed in collaboration with the city. Plans are in the works to equip the clinics for physical examinations as well. Up to three medications can be

prescribed per visit from a formulary of approximately 30 medications. The city pays a flat fee for each visit and for medications prescribed from the formulary, and employee copayments are waived for visits to the clinics.

Lee Memorial’s clinics offer the city and its employees several advantages. The clinics reduce high-cost employee visits to emergency departments. They also have a strong positive impact on productivity through convenience of location. Most city employees work within five minutes of a clinic, are seen within 10 minutes of their arrival, and can be back in the office within another 20 minutes. Also, early treatment of common illnesses has reduced absenteeism. What’s more, the clinics will soon be connected with Lee Memorial’s electronic health record, enabling the system to build a complete record of care for city employees who stay within the system.

Lee Memorial benefits from the clinics as well. The clinics build positive relationships with local employers—the success of the city’s experience has attracted the interest of other local employers. The clinics also create referrals to the system’s employed physicians and to its hospitals. The clinics have also helped move the system toward a more purchaser-centric culture. “For too long, healthcare providers have simply told patients what they need,” says John Wiest, Lee Memorial’s chief operating officer for business and strategic services. “Developing these clinics in collaboration with the city and its employees has made us more responsive to what the customer wants.”

For organizations pursuing a focused factories approach, the following capabilities will be needed.

People and culture. With their emphasis on consumer needs, focused factories require a strong patient- and purchaser-centric culture. As in the case of Lee Memorial, focused factory providers should actively seek conversations with patients and other purchasers of care to ensure that convenience, price, and service needs are being met.

Business intelligence. To keep prices low, focused factories will typically operate on a tight margin. Accurate costing of services—including both direct and indirect costs—is important to ensure that focused factories generate a positive margin. Focused factories that are part of a larger provider organization should also be part of the organization’s integrated electronic health record to ensure continuity of patient records.

Performance improvement. Efficiency of operations is a major strength of focused factory models. Performance improvement efforts should focus on minimizing patient wait times and streamlining the patient visit to maximize the focused factory’s value proposition. Focused factories will also need to standardize care around clearly defined sets of evidence-based protocols.

Contract and risk management. Exposure to performance risk will be low for most focused factories, given the limited menu of services they offer. Contract management efforts (with large employers, for example) should focus on simplicity of the terms for care (flat fees, guaranteed wait times, etc.) to make apparent the value of the focused factory model. These terms should be based on a clear understanding of customer needs and what the customer values most in a service.

For many providers, a focused factory strategy will supplement the provider’s broader strategy. For example, the approach may serve to complement a strategy of managing population health. Focused factories will typically require some level of integration (a retail clinic, for example, requires integration with primary care providers). Also, if the focused factory charges a flat fee for service, then it should be prepared for a limited degree of performance risk.

Integrated Care Networks

An integrated care network model involves both a formal integration of providers and a greater assumption of performance risk spreading across part or all of the care continuum. Providers collaborate to create integrated bundled services defined around an acute-care procedure (which may include pre- or post-acute care) or a chronic condition, such as congestive heart failure or diabetes. Providers could be integrated through consolidation or contractual relationships.

A number of payment methodologies are possible with an integrated care network. The network could offer a flat price (potentially risk-adjusted) for a bundle of services, or it could participate in a shared savings relationship with a purchaser in which a maximum price is established for the bundle of services, with the integrated care network sharing in any savings produced by improving the efficiency of care while maintaining the quality of patient outcomes. As multiple providers within a market begin to offer

similar bundles, providers could use retail-type pricing to compete for patients and other purchasers of care.

Early examples of integrated care networks include the Medicare Acute Care Episode demonstration projects and providers currently working to implement pilots of the PROMETHEUS Payment model. Payments for care under the PROMETHEUS Payment model, for example, are based on evidence-informed case rates (ECRs). An ECR is a budget for an entire care episode that includes all covered services, bundled across all providers that would typically treat a patient for a single condition or procedure. ECRs have several components: the clinically indicated costs of treating a condition or performing a procedure, adjusted for the severity and complexity of each patient’s condition; an allowance for potentially avoidable costs (reductions of which create a bonus pool to be shared among the providers); and an allowance for a margin to account for return on capital assets and reinvestment in business operations.

Within the capabilities grid on p. 29, integrated care networks would fall on the right side of the grid, below episode bundling and disease and chronic care management. In building their capabilities, integrated care networks will need to focus especially on the following.

People and culture. To deliver effective bundles of services or coordinated care for a specific population (e.g., patients with diabetes), integrated care networks will need to develop cross-continuum “communities of practice.” Communities of practice are microsystems comprised of related clinicians working collaboratively on the treatment of a specific condition or disease.

Business intelligence. Longitudinal costing skills become critical as integrated care networks attempt to bundle services and pricing across a continuum of providers. The networks must also be able to compare those costs with procedural outcome and condition management measures for the patients they serve and the purchasers of their bundled services.

Performance improvement. Integrated care networks will need to focus on delivering a consistently high level of quality across the care continuum. Also, they will need to effectively deploy their clinical communities of practice to optimize cross-continuum care pathways—including care transitions between providers along the pathway.

Contract and risk management. Network development and funds management emerge as critical skills for integrated care networks to effectively motivate and manage their cross-continuum communities of practice.

Developing an algorithm for distribution of revenue from bundled payments or from shared savings will be complicated, especially in cases where the network is not consolidated, but bound contractually. Factors contributing to this algorithm would include such considerations as the amount of savings a provider generated relative to a baseline for the network, amount of time or activities the provider contributed in delivering care, or the provider's contribution to achieving positive patient outcomes.

Another complication will be the participation of hospital providers in chronic condition management care networks, where hospital admissions represent potentially avoidable costs. Hospitals will need to be part of such networks for treatment of acute conditions that do arise. However, they will likely experience reduced admissions and revenues and may require a share of savings from reduced admissions to mitigate financial impacts as they adjust to lower volumes.

Centers of Excellence

A centers of excellence model combines attributes of both focused factories and integrated care networks. Centers of excellence are organized around treatment of specific conditions and related procedures, typically at the complex tertiary end of a care delivery scale. They require tight integration of the medical specialties involved in treating the condition and performing the procedures that are the center's focus. Participants in the model are usually not multi-site providers. More frequently, they are organizations that draw from a regional or, in some cases, national patient population, with patients traveling to receive care. Centers of excellence differ from integrated care networks in that they typically are part of fully consolidated organizations, not members of a more loosely integrated, multi-provider network.

The Cleveland Clinic's institutes, in which departments of related medical specialties collaborate as unified institutes to offer patient-centered care, offer examples of centers of excellence. In 2010, Cleveland Clinic's Heart

and Vascular Institute announced an arrangement with home-improvement retailer Lowe's Companies, Inc., to provide Lowe's employees and their dependents in the company's self-funded medical plan with the option of scheduling qualifying heart surgery procedures at the Cleveland Clinic at an enhanced benefit rate. Under the plan, Lowe's covers all qualified patients' medical deductibles, coinsurance amounts, and travel and lodging expenses for the patient and a companion. Cleveland Clinic, in turn, charges Lowe's a flat rate for all services related to the procedure.

A flat-rate payment involves potentially significant performance risk for centers of excellence, corresponding to the complexity of the condition or procedure at issue and the possibility for complications. At the same time, centers of excellence can limit their performance risk to the services and procedures within their direct control—especially with respect to surgical procedures. In the Cleveland Clinic heart surgery model, for example, there is no guarantee—or continued exposure to risk—if a patient is discharged in stable condition but later develops a complication. Instead, the Cleveland Clinic relies on maintaining high-quality outcomes to minimize purchasers' concerns about additional costs related to complications. Negotiation of performance risk exposure for centers of excellence focusing on treatment of chronic diseases or conditions would be complex, given both the duration and range of services needed for effective treatment.

Centers of excellence may exist within a network of providers assembled by an integrator, such as a health plan, disease management company, or large employer (or its third-party administrator). A provider organization could also technically take on the role of integrator, but as the main contact point for the purchaser of care, it would have to be able to take on many payer-like attributes—something that few providers would have the skills or capital to assume. Centers of excellence have a contractual relationship with the integrator (not with other providers in the network).

On the capabilities grid on p. 29, a centers of excellence delivery model would fall toward the center to right, requiring capabilities for payment methodologies through episodic

bundling and—in the case of a chronic-disease focused center—chronic condition management. Capabilities needed for those pursuing a centers of excellence strategy would include the following.

People and culture. Centers of excellence will be responsible for organizing themselves and their care delivery around specific conditions or procedures, which will often require both intradepartmental and interdepartmental integration. A culture intensely focused on quality and process improvement will also be necessary for centers of excellence to maintain a “best in class” standing.

Business intelligence. Accurate data for both costing (activity-level) and quality will be needed to set pricing for service bundles and to demonstrate value to healthcare purchasers.

Performance improvement. To sustain the level of performance demanded by purchasers, centers of excellence will need to apply evidence-based practices to develop clinical value bundles, with a focus on optimizing the quality and price of the bundles.

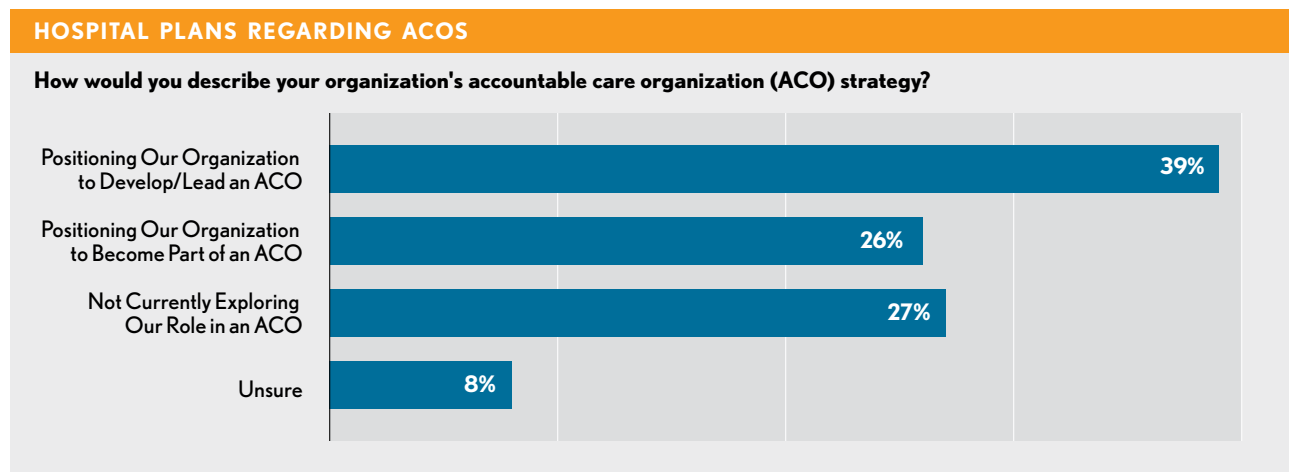
Contract and risk management. Centers of excellence will need to manage performance risk to thrive in an episode-of-care, bundled payment environment. Also, they will need to be able to organize contracts with institutional purchasers of their services.

As indicated earlier, a center of excellence model could be adapted to a wide range of providers and care services. There are, however, caveats: Some not-for-profit providers could find that defining themselves around a limited set of services will challenge the provision of community benefits that provides the rationale for their not-for-profit status. Also, centers of excellence might work best on a regional level, unless significant numbers of patients are willing to travel outside of their “comfort zone” near home for complex procedures.

Population Health Management

In this model, providers organize into an integrated, cross-continuum organization that contracts with employers, government purchasers, or health plans to manage the health of a defined population. This model will involve the most significant degree of risk, and it will require a patient-centric care delivery strategy emphasizing primary and preventive care to improve the health of the managed population and minimize more costly acute-care episodes.

Examples of population health management today include medical homes, Medicare’s recently completed Physician Group Practice demonstration project, and the ACO models defined in CMS regulations implementing the Affordable Care Act’s shared savings program. CMS’s ACO models have drawn significant attention. As part of its current state of value survey, HFMA asked organizations



Source: HFMA Value Project Survey, January 2011.

about their ACO strategy.²⁰ Almost 40 percent of respondents indicate that they are positioning their organizations to develop or lead an ACO, while another 26 percent are positioning their organization to be a part of an ACO.

CMS is predicting that between 75 and 150 ACOs will participate in the first three-year phase of a voluntary shared savings program defined by the Affordable Care Act, with up to 5 million Medicare beneficiaries receiving care from these ACOs.

As described in CMS's proposed rule for ACOs, released on March 31, 2011, ACOs participating in the three-year shared savings program will have the option of accepting both upside and downside risk for all three years of the program, or postponing acceptance of downside risk until year three. Those that accept two-sided risk will be entitled to a greater percentage of shared savings on the upside, while those accepting one-sided risk accept a lower percentage of shared savings by avoiding the risk of downside loss. In both cases, shared savings are at risk if the ACO does not achieve a range of quality metrics (the proposed regulation identifies 65 such metrics in five domains). On the downside, ACOs that perform well on quality metrics but miss performance benchmarks on expenditures will share fewer losses than ACOs that are low quality and low performance. The three-year program will continue to use Medicare's fee-for-service payment methodology, with savings or losses calculated at year end based on an ACO's ability to achieve quality metrics and reduce expenditures below that year's benchmark. CMS could eventually shift the payment methodology toward a partial or full capitation model if the three-year project is successful.

Assuming that a future population health management organization would operate under a PMPM capitated payment system, the organization would fall to the far right of the capabilities grid on p. 29. Those pursuing a population health management strategy would need to develop the following capabilities.

People and culture. Population health management organizations will need to orient themselves around the effective management of long-term chronic conditions and other key drivers of cost. Leadership will also have to

drive significant changes in culture. Compensation models will have to change from volume-based incentives to incentives focused on improving general measures of population health and on improving outcomes for specific conditions and procedures. Organizations will also need to recruit staff whose skills extend beyond the range of "normal health care" to experience in managing population health outcomes related to socioeconomic factors, such as housing, education, and nutrition.

Business intelligence. Business intelligence in a population health management model will center on per-member statistics such as PMPM costs. Decision support systems must enable predictive modeling and health risk assessment to support the organization's ability to manage utilization risk.

Performance improvement. Condition management within the population will be a key factor driving the success of a population health management organization. These organizations will also have to create means for developing accountability for outcomes among members of the managed population.

Contract and risk management. The ability to effectively predict outcomes will be fundamental as population health management organizations accept greater performance and utilization risk. Organizations will want to acquire or contract for actuarial skills to help estimate risk within the managed population.

The population health management business will be fundamentally different from an acute-care-focused healthcare system. Success will be defined by the ability to identify condition-specific standards to maximize population health outcomes and minimize preventable utilization of acute-care facilities. Costs will be measured longitudinally, on a per-member basis across the continuum of care, not per incidence of care provided. Organizations will focus on maximizing the number of lives covered, not the units of care provided. If the healthcare system moves toward population health management, hospitals will have to prepare for a much different future by reducing overhead costs and eliminating excess capacity.

²⁰ The survey was conducted before CMS published proposed rules for ACOs in the shared savings program.

STEPS TO SUPPORT VALUE-BASED TRANSFORMATION

The future state alternatives described are all in an early stage of development, and their viability will be tested over the next few years. What is clear, however, is the industry's movement toward value. Providers should begin now to plan for a value-based future, using these four steps:

1. Assess your organization's current and desired state on the value continuum. HFMA is developing a web-based tool tied to the four value capabilities and related skills that will be available on the Value Project's website (www.hfma.org/ValueProject). The tool will include a self-assessment questionnaire that identifies where you are on the value continuum, and what skills you should develop to achieve foundational and advanced status as a value provider. Or users can simply browse the tool to see what skills are recommended for the value capabilities. The skills are supported by strategies, tactics, and tools contributed by the providers interviewed for the Value Project. Organizations should also assess conditions in their local market to help predict future directions for change, considering such factors as alignment with clinicians, access to capital, sophistication and use of IT for clinical and financial decision making, success with performance management, market share, and competitive environment.

2. Prioritize the development of capabilities for your organization. After assessing your organization's current capabilities and those needed to reach the desired state, it will be important to examine areas in need of greatest skill development. What forces within your organization could constrain or accelerate your development of value capabilities, and how could you constrain negative forces and strengthen positive forces for change?

3. Institute proven practices to develop necessary capabilities. Reference the Value Project's future web-based tool for specific strategies and tactics to build skills within the four value capabilities. Also, watch for Value Project educational opportunities and HFMA publications featuring provider case studies on proven value-based practices.

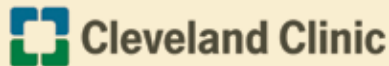
4. Develop a process to measure the progress of your organization's capability development. Align goals across your organization to create a uniform emphasis on achieving your value objectives, establishing realistic targets for short-term and long-term goals. Identify the right metrics for scorecards that cascade these goals throughout your organization. Be disciplined in measuring and reporting progress toward these goals by establishing baseline performance, seeking to understand the causes of progress and delay, and adjusting your goals accordingly. Prepare for missteps, but commit to learn from them as your organization moves toward a stronger value position.

In the coming months, HFMA will also produce a series of shorter reports dedicated to each of the four value capabilities outlined in this document, describing how providers can begin to bridge the gap between current practices and a value-based future. A fifth report will focus specifically on the evolving role of the CFO in a value-based healthcare system.

In his 2008 letter to Berkshire Hathaway stockholders, Warren Buffett wrote about a lesson he learned from his mentor, economist and investor Ben Graham: "Price is what you pay; value is what you get." We as a nation are now demanding that the price we pay for health care gets us value in return. It is our job as an industry to determine how we can best produce that value.

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VALUE IN HEALTH CARE: CURRENT STATE AND FUTURE DIRECTIONS

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