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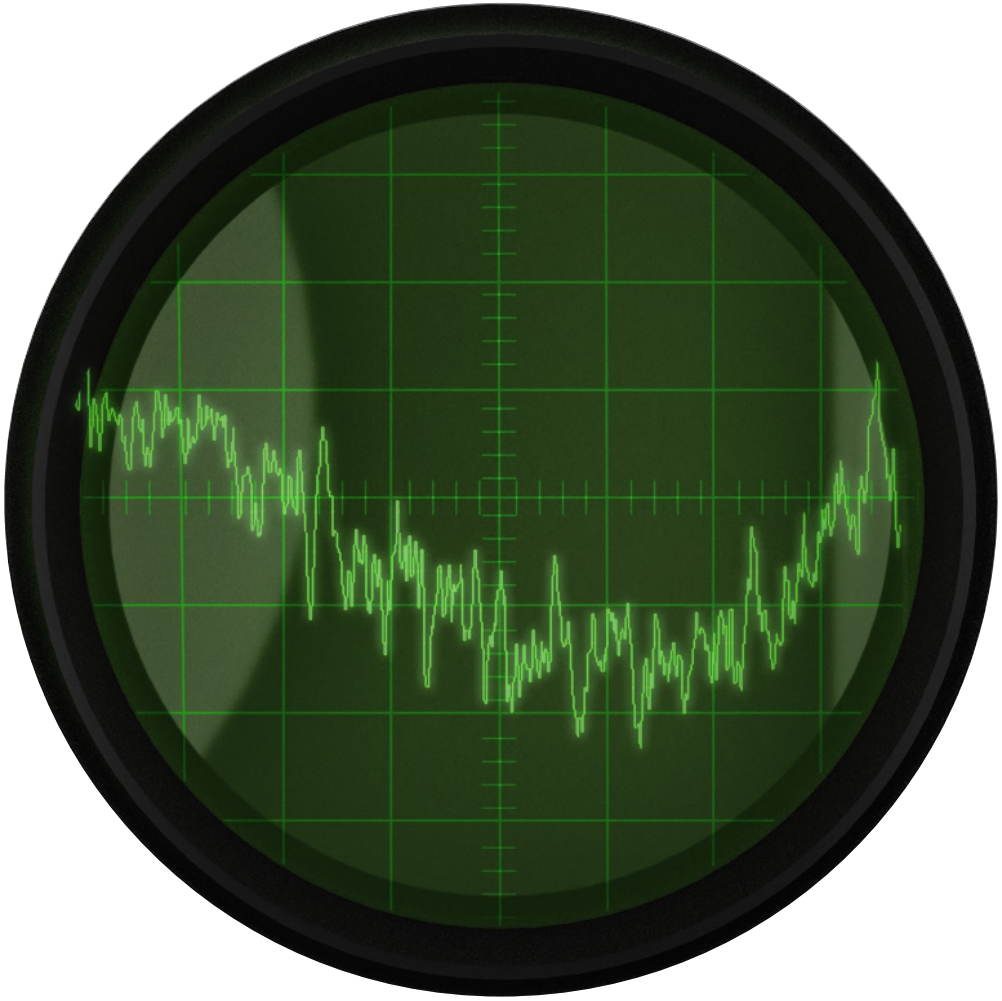


Value based care transformation: Providers

4-Part Blog Series | Blog 4

MAKING AN IMPACT THAT MATTERS since 1845

Part 4: Long-term success

What are some of the must-have requirements for a long-term roadmap to success in VBC and care delivery transformation?

Intro

As regulatory pressures, rising costs, needs for diversified business models, and other drivers have broadened the scale and scope of value-based care (VBC), our teams that support health care providers see common decision points and key challenges that most providers face. This four-part series examines the key moments at which these challenges arise, including:

- Part 1: Motivators convincing providers the time to act is now
- Part 2: Smart first steps to developing a plan for action
- Part 3: Investments that support current revenue streams but also position you for success in VBC

In this fourth and final part to the series, we highlight providers who have reached what we call the "tipping point" for VBC, using case examples to illustrate where organizations we have worked with have focused for long-term success in VBC. These providers have reached maturity in their payer relationships and are driving impact on patient outcomes, provider engagement, and market and financial results. Here, we highlight the essential capabilities that these providers have built to drive success.

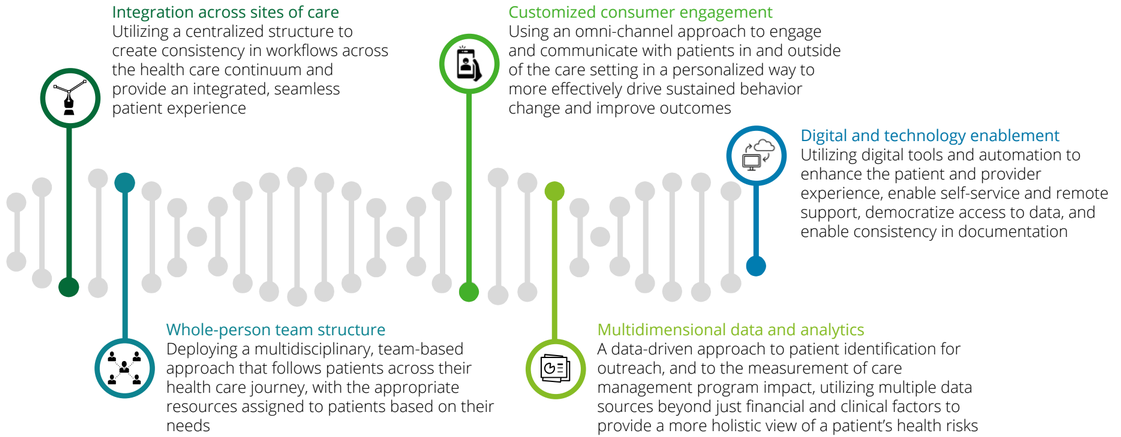
Value-Based Care Transformation: Providers | 4-Part Blog Series

Case example

A Midwest health system redesigned its care management model to enable better outcomes and lower total cost of care for patients covered by risk contracts. The redesigned model leveraged both embedded and remote care management team members in an analytically driven, multidisciplinary approach, with redesigned workflows and optimized staffing. To enhance patient identification for outreach, additional data sources were defined to improve its risk stratification model and give a more holistic view of patients' health needs by incorporating factors such as urgency, adherence behaviors, and social drivers of health. In its first year, this new model delivered critical total cost of care and quality metric impacts.

Care management

Key tenets to designing an industry-leading care management model:



A critical lever for health care providers to produce excellent clinical outcomes and reduce the total cost of care is highly effective care management. Mature VBC programs that have reached the "tipping point" recognize that ongoing contract success requires attributed patients to have coordinated and highly effective care delivery in order to improve their health and manage conditions outside of the care setting. Provider organizations recognize this requires an integrated care management model that leverages a multidisciplinary team, equipped with actionable insights to provide the most effective support and interventions to patients with impactable needs.

Case example

An academic medical center (AMC) engaged Deloitte to assist with the modernization of its interoperability platform to support growing population health initiatives. The AMC aimed to replace its current infrastructure with a more robust, scalable solution to provide better health data interchange and reduce the development and testing time needed to integrate with new data exchange partners (both internal and external). Using a hybrid agile delivery model, the team developed a new integration platform and migrated interfaces from the legacy system to the new platform. Integrations were built between the new platform and multiple external health partners to receive health information such as lab results and radiology reports for patients. The new platform provided physicians with more seamless access to patient data from external providers, enabling better coordination of care, identification of gaps in care, and potentially reducing redundant testing.

IT infrastructure and interoperability

With the emergence of new payment models, providers increasingly need broader data sets to offer customized support, measure the quality and outcomes of care, and improve the health of the populations they serve. An interoperable IT and data analytics infrastructure is necessary to aggregate data from disparate source systems (including clinical, operational, financial, and administrative) and improve transparency across all points of care. With robust infrastructure in place, provider organizations can enable the VBC analytics that are critical to driving tangible outcomes on their contracts and for their patients. This infrastructure typically covers the following areas:

Data aggregation and management	• Data aggregation into a central, unified data platform • Data governance • Master data management • Data normalization and transformation
Reporting and analytics	• User facing dashboards to support mission-critical KPIs and goals • Real-time performance statistics to improve quality and financial performance
Population health and care coordination	• Identification, segmentation, and prioritization of patients eligible for care management • Focused disease rosters and worklists to support population health management • Evidence-based and personalized care plans
Core applications and vendor management	• Systems to manage the delivery and documentation of care • CEHRT certified vendors • Submission strategy (vendor, attestation, claims data or other) • Consolidation of platforms for cost savings
Patient and provider engagement	• Comprehensive member engagement/outreach strategy • Robust patient and provider portal • Use of wearables/Internet of Things (IoT) strategies • Workflow and quality measure support
Standards-based (FHIR, eHEX, IHE) interoperability	• Easily accessible API catalog • Integration of data beyond the EHR (e.g., ERP, IoT, etc.) • Robust enterprise service business capabilities • Semantic/syntactic normalization

Case example

A statewide integrated delivery system set out to establish a clinically integrated network (CIN) to directly contract with employers and enter into value-based care arrangements. Deloitte was engaged to enable analytics and reporting capabilities for the newly launched CIN and assess the functionality of its existing electronic health record system (EHR) to support those capabilities. The team identified critical reporting metrics related to provider performance and care management to enable measurement of CIN performance. The team defined technology requirements and data interoperability needs for standing up these capabilities and conducted testing of initial technical architecture to support the reporting workflows in the EHR. These reporting and analytics capabilities helped to ensure a successful go-live for the CIN as well as success in value-based care arrangements, providing the ability for the CIN to measure provider performance against contracts and to more accurately identify patients who were likely to benefit from care management interventions.

Reporting and analytics

Once an organization has the IT infrastructure in place, analytically driven insights for VBC can be prioritized. The shift to VBC is driving providers to collaborate further with health plans and accelerate investments in key capabilities focused on predictive and prescriptive analytics across multiple domains. Typically, we see analytics investments prioritized within actuarial and finance, provider network management, care management, pharmacy, and clinical documentation. Here are a few examples of outcomes and analyses within these areas:

Actuarial and finance

- Cost and utilization trends and total cost of care opportunities
- Contract-specific financials including revenue, expenses, and margins
- In-network steerage

Provider network management

- Network sculpting to engage the right providers in the right contracts for identified patient populations
- Provider performance against contract parameters and clinical/operational outcomes

Pharmacy

- Ensuring patient engagement and ongoing monitoring of medication adherence
- Identifying opportunities to reduce overall drug costs related to total cost of care

Care management

- Identifying and stratifying populations in order to launch effective interventions
- Predicting risk to help identify populations most likely to benefit from VBC programs
- Executing care plans and interventions tied to outcomes and measurable incentives

Clinical documentation

- Improving accuracy and completeness of hierarchical condition category (HCC) documentation
- Improving the patient experience by better identifying patients for clinical programs

Case example

A large, multispecialty, hospital-owned medical group partnered with Deloitte to redesign physician compensation plans as part of its organizational strategy focused on developing infrastructure to support VBC growth. After an initial assessment, the engagement team facilitated a series of collaborative design sessions to determine the best compensation methodology to achieve desired goals, which included improving access to care and physician retention. The proposed design was socialized across the physician community to collect and incorporate additional physician feedback prior to implementation. The resulting plan rewards high performance in both patient experience and quality, while retaining the benefits of a productivity-based design.

Provider compensation

Provider organizations have historically promoted and rewarded maximum productivity for their providers, which has helped to drive volume and revenue. This is evidenced by the fact that the vast majority of physician incentive contracts are productivity based, favoring volume and activity over value and outcomes. Relative value units (RVUs), which have been the primary way that employers measure physician volume-based productivity, are featured in 73% of physician employment contracts.[1] However, in order to be fully successful in a VBC environment, the underlying structure for how providers are compensated needs to move more toward rewarding for quality and outcomes and less around volume. This doesn't mean moving entirely away from productivity metrics; however, it does mean placing more emphasis on quality and outcomes measures, team performance, and VBC contract payouts. Without changes to underlying provider compensation, a provider organization risks having providers misaligned from the strategic direction of the organization.

Case example

A nonprofit regional provider organization formed through the merger of two health systems aimed to transform its care delivery model to succeed in value-based contracting. It sought to significantly grow its commercial and governmental attributed lives, expand its CIN, and advance its risk level and access to premium dollars—including through movement into the health plan arena. Market conditions for its service area indicated a need to diversify revenue streams from its heavy reliance on fee-for-service (FFS), with new entrants disrupting traditional market share and competitive pressures around its primary and secondary service areas. In order to position its integrated health system and CIN to advance in the value-based care space, it set out to design an operating model that brings together defined functions and services from across the enterprise with newly built capabilities—all under a common leadership structure.

Deloitte was engaged to evaluate industry-leading operating models for vertically integrated health systems engaged in both the delivery and financing of health care. Insights were aggregated around lessons learned, best practices, and capabilities needed for optimal performance across patient outcomes, quality, financial metrics, and growth across commercial and governmental lines of business. The team developed a five-year roadmap and business plan for evolving the provider organization's current population health services into a more comprehensive, enterprise-focused, value-driven business unit with broadened capabilities, roles, responsibilities, and decision rights. Existing, mature capabilities were sourced from the newly formed enterprise to support VBC strategy, growth goals, and operations for the CIN, while other more nascent capabilities were placed on the roadmap for future development. The new operating model helped to drive alignment of care delivery from the provider organization's health system and CIN with payment model strategy, enabling delivery of high-quality care, improved outcomes, and a superior patient experience.

Leadership, governance, and operating model

Value-based care is more than just changing a payment model. The capabilities described in this series require coordination across an enterprise, with functions that may have been traditionally siloed from one another—such as care management, analytics, clinical quality, finance, and payer contracting—working in concert to achieve outcomes and goals that are different from those of a volume-driven business. As the focus shifts to population health, the creation of a team—with expertise in understanding drivers of success in value-based models of care delivery—is essential. Such transformation requires executive leadership to champion these efforts, clearly communicate the vision and strategy, and lead from the front. It also requires empowerment of staff and physician leaders to make decisions to gain alignment and center their teams around outcomes and value.

An effective operating model is essential for executive leaders to gain this alignment around VBC priorities. The operating model should describe how functions and services within an organization come together to support the vision and strategy. It should answer the following questions:

- How will decisions be made?
- Which functions and services should be shared across the organization?
- What new leadership roles or positions are required?
- What capabilities, processes, and technology are needed for success?
- How will we integrate with physicians?
- How should initiatives be approved, and how should funding be allocated?

While there is no one-size-fits-all operating model for value-based health care organizations, leading providers of value-based care ensure formal connections are made across critical functions to hardwire a coordinated approach to decision-making and institutionalize an integrated model of care.

Conclusion

Not all provider organizations have felt the sense of urgency to move into VBC just yet. And for those that have, outcomes have varied. The winners who have emerged are those on the leading edge of care delivery transformation. From our experiences with these organizations, we know that transformative success hinges on the wraparound services described in this series. We expect that as population health becomes the predominant approach to delivery of care, these services will become fully integrated within health systems and provider groups. Making the strategic choice to push toward the 40% tipping point could end up being the vehicle that creates savings to fund such initiatives. Wherever the funding is generated, investments in these core capabilities is what will continue to differentiate those players who succeed in VBC from those who encounter pitfalls along the way.

Sources:

1. Physician search engagements conducted by Merritt Hawkins, 2020 review of physician and advanced practitioner recruiting incentives and the impact of COVID-19, 2020.

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