Value-Based Care
What is Your Strategy?

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
About the Presenters

**Dr. Terrence R. McWilliams, Chief Clinical Consultant**, retired from the US Navy after more than 20 years as a family physician and clinical administrator in a variety of practice environments, including leading multispecialty clinical operations and physician-hospital alignment. He then spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, an acute care community hospital within a larger Rhode Island academic health system. As CMO, he supervised the Medical Staff Services Office and was responsible for quality of care/patient safety/risk management, clinical information systems, medical staff services, physician recruitment and clinical service line development. His involvement at the system level included creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

Terry received his medical degree from the University of Pittsburgh School of Medicine and a Master of Science in Jurisprudence (MSJ) in Hospital and Health Law from Seton Hall University School of Law.

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**Jarom E. Bowman, Senior Consultant**, comes to Healthcare Strategy Group after having served as manager of operations for a large clinically integrated physician-hospital organization (PHO) in the Cincinnati, OH area. Jarom was instrumental in the initial build and development of the organization and also played a key role in creating a regional PHO with a partner health system. His core area of expertise revolves around clinical integration and PHO/ACO development including the evaluation and implementation of organizational structure, governance, participation agreements, network development/alignment, financial modeling and assessing risk/value-based contracts.

Jarom holds a Bachelor’s of Science Degree in Finance from Brigham Young University-Idaho and a Master’s of Business Administration in Healthcare Management from Union College in Schenectady, New York.

**Jarom E. Bowman | Senior Consultant | (502) 814-1184 | jbowman@healthcarestrategygroup.com**
About Healthcare Strategy Group

- Healthcare Management Consulting Firm based in Louisville, Kentucky
- Focused *exclusively* on Physician Integration
- Experienced team with wide range of expertise across our services
  - **Physician Integration Strategy** Development
  - **Physician Integration** Implementation
  - **Physician Network & Practice Operations** Consulting and Management
  - **Accountable Care** Strategy & Infrastructure Development
## Meeting Objectives

### Agenda

<table>
<thead>
<tr>
<th>From Volume to Value</th>
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<tr>
<td>✓ Transformation</td>
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<tr>
<td>✓ Market Dynamics</td>
</tr>
<tr>
<td>✓ Dilemma – Solution</td>
</tr>
</tbody>
</table>

### Core Capabilities

| ✓ Eight Elements |

### Advantages & Barriers for Rural Hospitals/ Health System

### Strategic Considerations

| ✓ Get Your House in Order |
| ✓ Evaluate Strategic Partners |

### Question and Answer
From Volume to Value
From Volume to Value: Transformation

The downward pressures on healthcare spend have introduced increased levels of risk bearing reimbursement models – which are fundamentally shifting the business model of providers.

Paid for Volume

- An economic model driven by utilization and fee-for-service reimbursement
- Productivity, referral generation

Paid for Value

- Efficiency (high quality/low cost), manage comprehensive care, gatekeeper
- Cost center

Transition

Physician Role

- Productivity, referral generation

Hospital Role

- Profit center

Patient Acquisition

- Broad referral network

Patient attribution to PCP/defined patient populations

Revenue Source

- IP Admissions, procedures, & OP encounters

Achieving quality and cost targets (reducing total costs PMPM)

Margin Driver

- Expansive acute care platform

Population health management (chronic disease/case management)
From Volume to Value: Transformation

The downward pressures on healthcare spend have introduced increased levels of risk bearing reimbursement models – which are fundamentally shifting the business model of providers.

1. Federal Legislation
   - MACRA (SGR Fix)

2. Payers
   - Enables Transformation
   - Shift Financial Risk
   - Consolidate & Collaborate

3. Providers
   - Accelerator

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

<table>
<thead>
<tr>
<th>Year</th>
<th>All Medicare FFS</th>
<th>FFS linked to quality</th>
<th>Alternative payment models</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>85%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>2018</td>
<td>90%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Different markets will experience different rates of change in the transition towards value based on a variety of market-specific drivers.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competitors participating in CMS alternative payment models (i.e. MSSP ACO, BPCI, CJR)</td>
<td>Local commercial payers aggressively narrowing their provider networks in order to better control costs and outcomes</td>
</tr>
<tr>
<td>Competitors forming commercial ACOs or clinically integrated networks</td>
<td>Employers increasing willingness to offer narrow network to employees as a means to control cost</td>
</tr>
<tr>
<td>Direct to employer contracting (i.e. narrow networks)</td>
<td>Consumers increasing willingness to accept narrow network as means to control premiums</td>
</tr>
<tr>
<td>Competitors launching provider owned health plans</td>
<td>Increasing enrollment/ prevalence of Medicare Advantage plans</td>
</tr>
<tr>
<td>Competitors increasingly adopting commercial risk/value based contracts</td>
<td>Risk/value based contracts broadly taking root</td>
</tr>
<tr>
<td>Competitors expanding geographic footprint through provider and hospital acquisition</td>
<td>Payers consolidating (national phenomenon of mergers and acquisitions)</td>
</tr>
</tbody>
</table>

- Local commercial payers aggressively narrowing their provider networks in order to better control costs and outcomes.
- Employers increasing willingness to offer narrow network to employees as a means to control costs.
- Consumers increasing willingness to accept narrow network as means to control premiums.
- Increasing enrollment/prevalence of Medicare Advantage plans.
- Risk/value based contracts broadly taking root.
- Payers consolidating (national phenomenon of mergers and acquisitions).
- Rapid growth in private exchanges.
From Volume to Value: Dilemma – Solution

Strike a balance between moving too fast and moving too slowly in the transition towards risk/value.

**Too Fast**
- Prematurely subject organization to financial risk
- Wasted effort... won’t be able to service new arrangements
- Reimbursement erosion... reduced FFS rates
- Unnecessary infrastructure investment

**Well-Timed**
- Transition contracts strategically while building capabilities.

**Too Slow**
- Accept value/ risk-based reimbursement before building sufficient PHM capabilities

**THE STRATEGY**
- Health systems and provider networks must continue operating in and taking advantage of the current environment while designing care delivery for the future by investing tactically in the competencies to manage health and populations.

**Focus on fee for service and delay building PHM capabilities and entering risk-based world**
- Lost market share through tiered/narrow networks
- Reduced utilization driven by other organizations
- Limited physicians/ providers left to align with
- Allowing others to dictate your future
Core Capabilities
Core Capabilities: Eight Elements

Eight Core Elements essential to building a population health management platform capable of managing an array of alternative payment and care delivery models in this era of value-based care.

Eight Core Elements

1. Vision & Culture
2. Structure & Governance
3. Financial Alignment
4. Data Systems
5. Engaged Provider Network
6. Patient Engagement
7. Care Management
8. Quality Improvement

Four Core Operational Functions include Care Coordination, Information Technology, Contract Management and Network Development/Provider Engagement.
Eight Core Elements: Vision & Culture

A clear **Vision** and an adaptable **Culture** are catalysts for change and together form the foundation of Clinical Integration.

**Vision Development Checklist**

- Understand and agree what the CIN is and what it is not
- Clarify why the creation of a CIN is necessary and what it will enable primary stakeholders to do that they can’t do without it
- Identify the individual value proposition for each stakeholder group
  - Patients
  - Physicians and other direct care practitioners
  - Hospitals and other facilities
  - Payers
- Define high-level goals and objectives
  - Forecast what the organization will look like 2-5 years down the road

**Sample Vision Statements**

*The region’s preferred network of innovative healthcare professionals providing the highest quality of care at the greatest value.*

*The (CIN) is a unique, regional health organization that brings together exceptional physicians and hospitals to better serve the community by delivering healthcare services and resources that achieve better health, better care at lower cost.*
Eight Core Elements: Structure & Governance

An inclusive legal **Structure and Governance** model forms the base of an effective Clinically Integrated Network.

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3 Key Considerations

- **Organizational Structure**
- **Governance Model**
- **Administrative Structure**

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Example Committee Structure

<table>
<thead>
<tr>
<th>Finance/Contracting Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Budgets</td>
</tr>
<tr>
<td>- Incentives</td>
</tr>
<tr>
<td>- Financial performance</td>
</tr>
<tr>
<td>- Contracting strategy</td>
</tr>
<tr>
<td>- Network planning to support contract execution</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Establish and monitor quality, utilization and overall clinical performance</td>
</tr>
<tr>
<td>- Clinical protocols and care guidelines</td>
</tr>
<tr>
<td>- Care management oversight</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Systems Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Oversight of selection and implementation of data systems</td>
</tr>
<tr>
<td>- Ongoing evaluation of data system needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Advisory Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Physician participation criteria</td>
</tr>
<tr>
<td>- Oversee physician quality and compliance</td>
</tr>
<tr>
<td>- Peer review</td>
</tr>
<tr>
<td>- Oversight of credentialing</td>
</tr>
</tbody>
</table>
**Eight Core Elements: Financial Alignment**

*Financial Alignment* means aligning the economic incentives of participating providers and hospitals to get everyone rowing in the same direction.

<table>
<thead>
<tr>
<th>COF</th>
<th>CONTRACTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Identify and proactively seek out value-based contract opportunities in the market</td>
<td></td>
</tr>
<tr>
<td>✓ Carry out all payor contract negotiations for value-based contracts</td>
<td></td>
</tr>
<tr>
<td>✓ Develop in-house capabilities to model financial implications of new contracts</td>
<td></td>
</tr>
</tbody>
</table>

**Alternative Payment Models**

- **Degree of Financial Risk**
  - **least**: No Downside Risk
  - **most**: Downside Risk

- **Example Funds Flow**
  - **$\$\$ (+/−)**
  - **CIN**
  - **Physicians**
  - **Specialists**
  - **PCPs**
  - **Employed**
  - **Indep.**

Healthcare Strategy Group
American Hospital Association Health Forum
### Eight Core Elements: Data Systems

**Robust Data Systems** support the CIN’s clinical and business functions and permit the flow of data required to make informed decisions.

<table>
<thead>
<tr>
<th>Capability</th>
<th>Functionality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Collection and Integration</strong>&lt;br&gt;Ability to integrate claims data with clinical data at the patient level</td>
<td>- Collection, storage and access to a single point of electronic health information across the continuum.&lt;br&gt;- Health Information Exchange (HIE) to collect and share data from multiple sources and providers operating on different systems across the network.&lt;br&gt;- Centralized data warehouse to effectively integrate all necessary data from multiple sources (i.e. clinical, administrative, financial, claims, etc.).</td>
</tr>
<tr>
<td><strong>Data Analytics</strong>&lt;br&gt;Ability to analyze integrated data to target cost savings, care management and performance improvement opportunities</td>
<td>- Risk stratification capabilities to identify and manage high risk patient populations for the CIN’s complex care management program.&lt;br&gt;- Ability to track a single patient over multiple care episodes.&lt;br&gt;- Ability to model the financial feasibility of prospective risk/value-based contracts using both clinical and claims data.&lt;br&gt;- Physician-level patient attribution and performance measurement.&lt;br&gt;- Front-end analytics for providers to assess clinical results, manage referrals, access protocols and track performance in CI program.</td>
</tr>
<tr>
<td><strong>Data Reporting</strong>&lt;br&gt;Ability to share data with end-users and key stakeholders</td>
<td>- View and update a single patient record as appropriate for the entire care team and the patient in support of care transitions.&lt;br&gt;- Link disease registries directly to EMR.&lt;br&gt;- Develop measurement and reporting systems that combine multiple data sources.&lt;br&gt;- Offer flexibility to adjust to changing payer metrics and reporting requirements.</td>
</tr>
</tbody>
</table>
Eight Core Elements: Provider Network

Selecting an Engaged Provider Network to drive Quality, Patient Engagement, and Care Management forms the backbone of the clinical transformation that must occur to successfully shift from fee-for-service to value.

Network Development

- Routinely assess network size and mix of providers needed to support contracting and organizational strategy
- Develop ongoing participating provider criteria/requirements
- Develop provider credentialing capabilities

Building the Right Network

Cultural Fit

- Target high-quality providers likely to further the CIN’s mission
- Identify physicians and other partners who are excited about building a new and innovative model of care
- Identify providers who work well with the broader healthcare community and other CIN partners

Full Continuum of Services

- Identify and select a robust network of primary care physicians and specialists
- Develop a strategy for aligning provider organizations in the post-acute space

Qualifications and Infrastructure

- Baseline Criteria: Board certification, malpractice
- Ideal Criteria: Technical capabilities, data sharing connectivity (i.e. EMR and willing participation in an electronic health information exchange, etc.), care management resources (i.e. complex care management program, embedded care managers) and PCMH recognition
Eight Core Elements: Patient Engagement

Providers must explore more creative ways to effectively partner with patients in their care and provide them with the information they need to make informed decisions.

<table>
<thead>
<tr>
<th>4 Tips for Patient-Centered Care</th>
</tr>
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<tbody>
<tr>
<td>Communicate and educate</td>
</tr>
<tr>
<td>A well-informed patient is paramount to patient engagement. A patient (or caregiver) cannot be an active participant in a process that is not understood on a basic level. Nodding along may or may not indicate understanding. Best practice: employ the “repeat back” technique to ascertain exactly what the patient thinks is being communicated.</td>
</tr>
<tr>
<td>Address care in the patient’s environment</td>
</tr>
<tr>
<td>Previous provider initiatives focused on providing more in-depth patient education and ensuring that spoken instructions were reinforced by written materials. Under value-based reimbursement, providers must go a step beyond to understand and appreciate the patient’s circumstances and daily experiences outside the physician office. The patient’s care plan can then reflect this greater reality.</td>
</tr>
<tr>
<td>Incorporate patient preferences</td>
</tr>
<tr>
<td>Prior efforts at individual care plan development were very provider-centric, e.g., “Here is what you need to do to better manage your condition.” These plans often failed, because patients had no intention of following them. Best practice for CINs: Involve patients (and caregivers) in care plan development and ask them to honestly tell you what they are and aren’t willing to do.</td>
</tr>
<tr>
<td>Mitigate barriers</td>
</tr>
<tr>
<td>Language, culture, emotions, pride and socioeconomic conditions are potential barriers to patient understanding and compliance. Addressing these in the practice setting is critical to customizing the care plan and predicting compliance.</td>
</tr>
</tbody>
</table>

Patients who aren’t engaged don’t make good partners.
**Eight Core Elements: Care Management**

**Identifying “high utilizers,” managing their care, and improving their health is critical when managing the total cost of care. Effective care management requires designing, coordinating and executing interventions across the continuum of care.**

<table>
<thead>
<tr>
<th>To Achieve This:</th>
<th>Answer These Questions:</th>
</tr>
</thead>
</table>
| Risk Stratification                   | • What financial (i.e. average claims expense) and clinical (i.e. multiple admissions, heavy ED utilization, comorbidities, etc.) indicators will be used to define high-risk patients?  
   • What are appropriate thresholds for these indicators?  
   • What percentage of the patient population will be targeted for complex care management is cost effective? |
| Operating Model                       | • How will care coordinators work with providers to coordinate inpatient care, discharges, follow up calls and home visits to ensure proper transitions? |
| Staffing Model                        | • Will care coordinators be concentrated centrally or deployed peripherally in the offices and hospitals or a combination of both?  
   • Will the concentration of care managers be relatively fixed or flexible?  
   • What is the appropriate staffing ratio of high risk care coordinators to “high-risk” patients?  
   • What are the qualifications of the care coordinators?  
   • How will chronic disease educators be deployed? |
| Patient Engagement                    | • What best practices and standards will be developed around patient education and engagement?  
   • How will the effectiveness be assessed? |
| Transitioning Patients Between Care Settings | • What bridging programs will be developed for patients moving from inpatient to the post-acute setting or office-based care? |

Care management is integral to achieving cost savings & managing populations.
Eight Core Elements: Quality Improvement

Qualifying, selecting, implementing, modifying, and eventually retiring quality measures is an ongoing, active process.

- Qualify
- Select
- Implement
- Modify
- Retire

Include Financial and Utilization Measures
Advantages & Barriers
### Advantage & Barriers for Rural Hospitals/Health Systems

Rural hospitals and health systems are uniquely positioned to manage population health but may need a partner to help defray barriers to entry.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined Population</td>
<td>Lack of Capital</td>
</tr>
<tr>
<td>Defined Medical Resources</td>
<td>Significant Cost</td>
</tr>
<tr>
<td>Options</td>
<td>Lack of Infrastructure</td>
</tr>
</tbody>
</table>

**Your Greatest Asset:** Concept consistent with traditional mission of promoting health and wellness of the community served.
Strategic Considerations
# Strategic Considerations: Get Your House in Order

| **Shared Vision for Success** – *Outline the strategic purpose and long-term vision* |
| **Market Dynamics Assessment** – *Analyze the local healthcare landscape and key market drivers to determine the true pace at which the local market is transitioning to value* |
| **Gap Assessment** – *Identify gaps in the capabilities the organization will need to compete in a value-based care environment* |
| **Financial Modeling** – *Illustrate the financial implications of transitioning toward value* |
| **Detailed Action Planning** – *Prioritize immediate and long-term tasks to address identified gaps and execute strategic vision* |

## OUTCOME

- Determine specific actions required to effectively function in a value-based care environment.
### Strategic Considerations: Get Your House in Order

Regardless of specific action item that result from the assessment, the following need to be addressed:

- Educate your board, physicians and management team
- Define your long-term strategic vision
- Identify physician leadership
- Standardize practice operations across employed physician network
- Firm-up relationships with medical staff/ independent physicians
- Organize broader medical community/ resources

**OUTCOME**

- Assures optimal organizational function while transitioning to value-based care.
- Fosters maximum desirability as partner in strategic alliances.
Addressing identified gaps often leads to considering strategic partnerships. Determine **what is desired from these collaborations**.

<table>
<thead>
<tr>
<th><strong>Check</strong></th>
<th><strong>Cultural compatibility</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check</strong></td>
<td><strong>Previous relationship/ experience working together</strong></td>
</tr>
<tr>
<td><strong>Check</strong></td>
<td><strong>Experience managing populations and financial risk</strong></td>
</tr>
<tr>
<td><strong>Check</strong></td>
<td><strong>Complimentary service areas</strong></td>
</tr>
<tr>
<td><strong>Check</strong></td>
<td><strong>Capital (Expertise &amp; Financial)</strong></td>
</tr>
<tr>
<td><strong>Check</strong></td>
<td><strong>Infrastructure Support (Management, IT, Data Analytics &amp; Care Management)</strong></td>
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</tbody>
</table>

**OUTCOME**

- Determines criteria against which potential partners can be assessed.
- Fosters a lasting and long-term partnership that will greatly enhance your ability to thrive in value-based care and retain your independence.
One common misconception is that you can’t do anything significant until you have obtained the FTC’s “clinically integrated” stamp of approval.

**Strategic Positioning**
- Establishing the legal and organizational structure gives participants a seat at the table.
- Participants are synergistically creating something bigger than themselves.

**Contracting**
- Apply to become a MSSP ACO.
- Negotiate and enter into shared savings/risk arrangements with commercial payers.
- Directly contract with employers.
- Sponsoring entities’ employee health plan.

**Scale**
- Joint investments in technical resources, care management infrastructure, staff and other costly population health management capabilities — capabilities that would otherwise be developed individually.

Clinical integration is a marathon not a sprint... and can be accomplished through incremental investments that don’t break that bank!

**Immediate Advantages of Pursuing Clinical Integration**
Question and Answer
For More Information

For an electronic copy of today’s presentation, email Jarom at jbowman@healthcarestrategygroup.com

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