



Transformation to Value: A Leadership Guide

Table of Contents

DIMENSIONS OF HEALTH CARE TRANSFORMATION1
CHANGING STRATEGY AND CULTURE5
STRUCTURE AND INVESTMENTS 18
OPERATIONS AND ACCOUNTABILITY 28
PERFORMANCE MEASUREMENT..... 39

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Transformation to Value: A Leadership Guide

INTRODUCTION TO THE DIMENSIONS OF HEALTH CARE TRANSFORMATION

Who We Are

The **Health Care Transformation Task Force** (Task Force) is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change from volume of services to value of care, both for ourselves and our industry. To achieve this, we commit to have 75 percent of our respective businesses operating under value-based payment arrangements by 2020.

Background on the Transformation to Value Project

Shifting from traditional, volume-driven fee-for-service to value-based care is highly challenging, even for the most sophisticated businesses. Health care organizations committed to transforming to value-based payment and care delivery models must often make significant changes to their strategic direction and operating structures. How much work needs to be done to achieve value transformation, however, depends on many factors such as level of commitment, organizational complexity, cultural dexterity, level of change currently underway, and desired goals.

Transformation can be risky, even for those who are further along the transition to value continuum. Organizations must weigh a multitude of variables in their planning processes, and often use internal vetting practices that draw upon both internal and external shared learnings as well as return on investment (ROI) calculations to align transformational goals with current business models. In particular, shared learnings from businesses that have implemented value-based care programs are critically important to help other organizations successfully navigate opportunities and pitfalls.

The Task Force's Path to Transformation Advisory Group created the *Dimensions of Health Care Transformation Strategy Framework* (Framework) to assist health care leaders as they design and implement their transition to value. The Framework is built on the



collective experience and wisdom from organizations that are at the vanguard of value-based payment and care delivery. It reflects introspective questions that change leaders should ask in building out a transformation strategy.

The Framework also provides the foundation for a series of interviews, and subsequent analysis, that the Task Force conducted to provide additional context on the path to transformation continuum and allow decision makers to benchmark themselves against similar organizations that are actively moving toward value-based care. The output from this analysis, including shared learnings and comparative processes, will be featured in four additional reports.

The Dimensions of Health Care Transformation: A Strategy Framework

The Framework helps organizations assess their transformational maturity across a set of **business dimensions** (vertical axis) in which they can expect to make transformative changes through three **levels** (horizontal axis): (1) concept; (2) execution; and (3) sustainability. This Framework charts a course for how organizations can be successful in culturally, structurally, and operationally transitioning to value-based care.

The Framework's current **business dimensions** are intended as a core set, with additional dimensions added as appropriate. The example questions and categories provided represent activities that may or may not be happening simultaneously, rather than prerequisites that must be met before an organization may move to the next level. In sum, the Framework is intended to be a dynamic tool, with additional dimensions added over time.

The first level – **concept** – assesses the needs of the communities or markets to be served and how health care organizations can best tailor value-based care models to serve those needs. Due to the complexities of value-based care arrangements, the concept stage requires education of, and buy-in from, leadership groups and an organizational commitment to the culture change necessary to effectively implement value-based care models.

The second level – **execution** – involves delivering on an action plan for change, including setting a course and timeline for transitioning from fee-for-service to value-based payment models. The leadership education and buy-in from the concept stage is now shared more broadly with the organization. Cultural and operational plans are established to ensure alignment and to promote organizational accountability so that internal teams move toward achieving common goals on consistent timelines, with an established feedback loop to promote continual improvement. All dimensions from the concept stages are now operational and individual/team incentive plans – financial, cultural and/or operational – are in place to tie personal accountability to organizational commitment.

The final level – **sustainability** – envisions an ideal end state of organizational transformation that reflects aligned goals and objectives, as well as measurable progress toward lower costs and improved quality, outcomes and patient experience. Within the sustainability level, operational scale is achieved consistent with the desired organizational plan, but is not viewed as satisfactorily sustainable by itself.

For most organizations, “sustainability” is an aspirational destination that has not yet been fully achieved. Thus, the definition and specificity of what it means to sustain transformative efforts will likely

DIMENSIONS OF HEALTH CARE TRANSFORMATION: A STRATEGY FRAMEWORK



Dimensions		
Concept	Execution	Sustainability
<p>Strategy and Culture</p> <p><i>Organization</i></p> <p><i>Governance</i></p> <p><i>Executive and Clinical Leadership</i></p>	<p>What is the formal organizational structure, and what are the roles of organizational participants? What partners are needed? Are there benefits to using a separate corporate structure or entering into joint ventures?</p> <p>How does governance define the value-based care proposition, and how does governance establish the organization's commitment to "cultural reengineering" around person-centered care? How are consumer priorities identified and achieved? How are performance metrics defined?</p> <p>How does executive and clinical leadership plan, execute, and evaluate the cultural reengineering plan? What other strategic priorities are necessary for execution? What performance metrics are established to review progress?</p>	<p>What is the formal organizational structure, and what are the roles of organizational participants? What partners are needed? Are there benefits to using a separate corporate structure or entering into joint ventures?</p>
<p>Structure and Investments</p> <p><i>Infrastructure</i></p> <p><i>Workforce</i></p> <p><i>Business Focus Areas</i></p>	<p>What infrastructure is needed to support the value-based model of care? How is infrastructure assessed, built, and maximized? What are the capital needs and available financing resources?</p> <p>What skills, competencies, and roles are needed to support the new models of care delivery? How are staff recruited or re-trained to incorporate new staff roles and functions? What are the performance metrics?</p> <p>How are initial payment models or care delivery models identified? How are distinct payment models/care delivery models integrated? How is consumer engagement planned and achieved?</p>	<p>What infrastructure is needed to support the value-based model of care? How is infrastructure assessed, built, and maximized? What are the capital needs and available financing resources?</p>
<p>Operations and Accountability</p> <p><i>Operational Alignment</i></p> <p><i>Financial Incentives</i></p> <p><i>Quality Measurement</i></p>	<p>How are the objectives of value-based care managed across multiple operational service lines? Who is responsible for operational alignment planning and its execution? What training activities are necessary for success?</p> <p>How are operational and clinical managers incentivized to ensure movement towards value-based care goals and objectives? Who is responsible for reviewing performance of the operational and clinical managers?</p> <p>How does the organization evaluate and measure progress on quality improvement? Who is responsible for collecting, reviewing and acting upon quality measures?</p>	<p>How are the objectives of value-based care managed across multiple operational service lines? Who is responsible for operational alignment planning and its execution? What training activities are necessary for success?</p>
<p>Performance Measurement</p> <p><i>Process and Outcomes Evaluation</i></p> <p><i>Financial Modeling</i></p>	<p>What mechanisms are in place to evaluate the implementation, progress, and outcome of value-based care programs? What types of feedback loops are in place to make adjustments based on evaluation results?</p> <p>What information does the organization review to perform financial modeling and determine predicted returns on investment? Who is responsible for reviewing financial performance and making refinements?</p>	<p>What mechanisms are in place to evaluate the implementation, progress, and outcome of value-based care programs? What types of feedback loops are in place to make adjustments based on evaluation results?</p>



evolve over time and will be subject to continual advancement/refinement. One constant, however, is the need for continuous improvement to remain successful in providing high-quality, affordable person-centered care.

Health care organizations' ability to move along the transformation continuum is often dependent on external factors over which the organization has little direct control. External factors may include state insurance regulations; federal policies and requirements; local health information infrastructure; and willingness from others to partner in value-based arrangements. The confluence of these factors will dictate the overall readiness of local markets to support value-based care and will play a large role in whether organizations are able to pursue value transformation.

At present, the Framework does not seek to identify specific external factors as prerequisites for, or potential impediments to transformation; rather, it recognizes that the speed and scope of transformation may be restricted by the current ecosystem in which individual health care organizations operate.

Conclusion

In a world of rapid change and increasing public pressure to provide higher quality, lower-cost health care, transformation to value has become an imperative for all segments of the industry. Yet many organizations still lack the substantive knowledge and tools to successfully make the leap. Through the Dimensions of Health Care Transformation Framework and related whitepapers outlining real-world transformational journeys and learnings of industry leaders, the Transformation to Value project aims to bridge this gap by serving as the groundwork of resourceful experiences for business leaders to reference when building and executing their own transformation blueprints.

Acknowledgments

This is a product of the Health Care Transformation Task Force under the leadership of the Path to Transformation Advisory Group. The Path to Transformation Advisory Group is co-chaired by Jason Dinger, Chief Incubation Officer, Ascension; and Brigitte Nettesheim, President, Transformative Markets, Aetna. The Path to Transformation Advisory Group is comprised of Task Force members who are dedicated to identifying issues and challenges that impact the path to value transformation. The Advisory Group addresses both internal operational challenges of moving toward broad adoption of value and external, atmospheric meta-issues that challenge transformation efforts for health care organizations.



Transformation to Value: A Leadership Guide

CHANGING STRATEGY AND CULTURE

Who We Are

The **Health Care Transformation Task Force** (Task Force) is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change from volume of services to value of care, both for ourselves and our industry. To achieve this, we commit to have 75 percent of our respective businesses operating under value-based payment arrangements by 2020.

Introduction

The transformation from fee-for-service to value can be highly challenging, even for the most sophisticated health care organizations. The process of transformation requires strong leadership, well-defined strategic and operational plans, appropriate resources, and exceptional commitment and ongoing dedication at all organizational levels. Despite the importance of value transformation, there are few public resources that provide strategic guidance and examine broader trends in organizations' transformation experiences.

The Health Care Transformation Task Force (Task Force) has created a *Dimensions of Health Care Transformation Framework* (Framework) to help health care organizations assess their transformational maturity along the value-based payment and care continuum. The structure of the Framework provides the foundation for a series of interviews with provider and payer organizations that are deeply engaged in the transition to value. These interviews offer insight into the process of transformation: the decisions that organizations must make as they move along the value continuum, the options available to them and their consideration of alternative approaches, the rationale for particular decisions, and the subsequent results of those decisions.



Shared learnings related to changing organizational strategy and culture, as well as new structure and investments that organizations have put in place to facilitate their transition to value, are captured in this report. The report presents this information in a consistent way: (1) common approaches; (2) varying approaches; and (3) lessons learned.

The transformation to value is a long and risky process. There is no clear roadmap to success, and each organization has unique needs and resources. Further, it will not be possible to fully assess the impact of the changes that organizations have made for several years yet to come. Rather than identify industry best practices for delivery system change, the approaches described below illuminate a broader plan for success. In some instances, there is significant alignment on the path forward; in others, the organizations interviewed diverge in their approaches. Together, these findings paint a detailed and diverse picture of the path to transformation to help guide organizations as they embark on their own journey to value.

Changing Strategy and Culture

In the first dimension of the Framework, Task Force members articulated three key components that either impact, or are impacted by, strategy and culture change. Those components are (1) Organizational Structure; (2) Governance; and (3) Executive and Clinical Leadership. The Framework provides examples of the types of questions that organizations should use to evaluate their progress toward strategy and culture transformation.

<i>Dimensions</i>		<i>Concept</i>	<i>Execution</i>	<i>Sustainability</i>
Strategy and Culture 	<i>Organization</i>	What is the formal organizational structure, and what are the roles of organizational participants? What partners are needed? Are there benefits to using a separate corporate structure or entering into joint ventures?		
	<i>Governance</i>	How does governance define the value-based care proposition, and how does governance establish the organization’s commitment to “cultural reengineering” around person-centered care? How are consumer priorities identified and achieved? How are performance metrics defined?		
	<i>Executive and Clinical Leadership</i>	How does executive and clinical leadership plan, execute, and evaluate the cultural reengineering plan? What other strategic priorities are necessary for execution? What performance metrics are established to review progress?		



When the Framework was created, culture change was highlighted by Task Force members as a key to successfully transforming to a value-based organization. Leaders in payer, provider, and purchaser organizations alike underscored the integral nature of successfully changing the culture within all levels of an organization to support value-based payment and care delivery. The enormity of that task was not lost on any of these leaders, as they also noted that successfully transitioning to a culture of value is one of the biggest challenges and hurdles to successful transformation. As most organizations then went on to point out in the interview process, culture change involves buy-in across an entire organization (i.e., clinicians, executives, administrative staff, and affiliated partners). This necessitates an overarching vision for transformation, dynamic and experienced leaders, and an appropriate level of organizational integration and local leadership buy-in to successfully transition within each market. These high-level assumptions and themes are borne out in the detailed analysis below.

Organizational Structure

Common Approaches

Independent of the overarching organizational configuration, virtually all organizations interviewed have implemented a structure that aims to achieve a balance between the standardization needed across an organization to facilitate high-quality and consistent care, and the customization needed to address organizational and population health needs across varied markets, regions, and lines of business. This generally involves close collaboration with clinical staff and leadership in specific localities who are closer to patients and market dynamics. These local leaders often adopt centralized resources and modify them for their specific markets, but still have overarching accountability to centralized leadership for the cost and quality of their markets. This balance of local and centralized leadership encourages a more rapid and successful adoption of new processes and structures than a purely centralized approach, while still enabling local markets to benefit from the knowledge, resources, and economies of scale that come with larger organizations. Likewise, centralized organizations can benefit from the knowledge of local markets and translate shared learnings to other markets.

“These very different market dynamics are variations upon a theme,” noted one interviewee. “We have to quickly identify what that theme is to maintain system consistency, [then] implement and tailor the program to what the market’s needs are.”

EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION

Also common among many interviewees was the importance of aligning with partners and providers who share the organization’s broader goals in achieving the desired structure and outcome, and who have the capacity to help build that vision.

“When picking partners...I think the alignment is more than just what assets either party would contribute, but definitely that culture and the vision and the fit of where we want it to be intentionally. That was so huge for us.”

EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION

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EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION



Varying Approaches

Organizational approaches to value-based payment transition fall along a continuum. On one end, an organization may develop parallel structures within their organization, where the new value-based payment infrastructure is separated from the current fee-for-service business, usually with the intention of merging these efforts over time. On the other end is a fully integrated value-based structure that forms the basis of the entire organization's payment and care delivery models. Hybrid structures fall somewhere in between, where value is integrated into the care and payment for certain populations or lines of business, but does not permeate an entire organization.

The organizations interviewed do not predominantly fall into any one of these categories, but rather represent this organizational continuum. Organizations that decided to pursue a parallel value-based care structure generally cited greater return on investment, stronger potential for change, and the need for a “learning laboratory” as reasons for segregating their fee-for-service from their value-based practices or lines of business. On the other end of the spectrum, organizations that pursued a fully integrated structure indicated a desire to provide seamless and consistent care, the need for effective oversight, and interactions and interdependencies across an organization that warrant a centralized approach.

A national nonprofit system moves toward care delivery integration

The path to transformation is a learning process, and after years of implementation of value-based programs, one organization is moving away from “parallel structures” and toward a more structurally integrated system of care delivery.

At the outset, this health system emphasized transformation over integration. Recognizing the variability across the many markets in which its hospitals are located, and the need to support and work within that market-specific context (e.g., geographic location, population, clinical profile, partner/competitor dynamics) the health system leadership decided to build accountable care organizations in various regions, allowing the ACOs to organically adapt and cater to local market dynamics, with the intention of integrating down the line.

The transformation experience of this organization, so far, has helped the leadership realize that there isn't enough “persistence, experience, leadership, and management” at the local level to guarantee continuity in management across the broader organization. While there's a recognition that local management and an understanding of local markets is critical to success, so too is standardized infrastructure, standardized metrics, and a centralized management structure that allows each region to integrate with the health system. The organization has thus concluded that ACOs have “many interactions and interdependencies that warrant a central approach,” and is transitioning to a more integrated care coordination network.

This health system learned a couple important lessons throughout this process that may advise other organizations in their transformation journey. First, the development of market-specific value-based organizations is a heavy lift; in retrospect, having an established infrastructure that could be replicated, generally, in various markets could have smoothed, and sped up, the process of transformation. In a similar vein, the organization has come to realize more acutely that “value-based purchasing arrangements are all synergistic,” and that centralized management and coordination of all value-based purchasing arrangements provides a foundation for widespread success.



The interviewees differ not only in the type of value-based care structure, but also in the pace with which they adopt (or encourage the adoption of) value. Some leaders noted the importance of a slow transition to value, which allowed more time to develop and mature the necessary organizational structure, while others emphasized a more rapid-yet-deliberate transition to fully capitated risk. Those emphasizing a slower transition to value were sensitive to the ability of smaller, less experienced organizations to take on downside risk. They therefore emphasized small gains in quality of care and value-based care delivery capabilities. The organizations supporting a more rapid transition to full capitation emphasized the value for providers in bringing on a partner with experience and awareness of the hard work required to set up a new structure:

“There are four key factors. One, that the premise actually really works. Two, that when people get it, they want to move ahead way faster. It’s just helping them understand where it needs to go. Three, that it needs incredible diligence and hard work. Four, that it takes a year to actually get a delivery system ready to do this. You have to invest for a year in building for implementation a year later.”

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Finally, interviewees differed in their value approaches by organizational type. Payers tended to have a large book of value-based programs operating simultaneously, often encompassing a broad spectrum and many different markets. Providers tended to have fewer types of value-based models, but size and geographic dispersion appeared to play a role in the scope of diversity of programs.

Examples of Value Initiatives by Organization Type	
Organization Type	Value Initiative
National Health System	<ul style="list-style-type: none"> Accountable Care Organization Bundled Payments Risk-Based Contracts (Medicare Advantage)
National/Multi-State Payer	<ul style="list-style-type: none"> Accountable Care Organization Episode-Based Payment Global Risk Hospital Pay for Performance Partial Physician Capitation Patient-Centered Medical Home Specialty Pay for Performance (Cardiology and Orthopedics)
National Provider Partner	<ul style="list-style-type: none"> Accountable Care Organization Bundled Payment Full Capitation Provider-Sponsored Health Plans Risk-Based Contracts (Medicare Advantage)
Regional Health System	<ul style="list-style-type: none"> Accountable Care Organization Bundled Payments Direct Purchasing PACE Risk-Based Contracts (HMO and PPO)



Examples of Value Initiatives by Organization Type, Cont.

Regional Federally Qualified Health Center	<ul style="list-style-type: none"> Accountable Care Organization Patient-Centered Medical Home Risk-Based Payer Contracting
Single-State Payer	<ul style="list-style-type: none"> Patient-Centered Medical Home
Single-State Provider	<ul style="list-style-type: none"> Accountable Care Organization Bundled Payments

Lessons Learned

In pursuing a new organizational structure that facilitates the transition to value, there are a few key lessons expressed by the interviewees. First and foremost is that the path to transformation is long and difficult. A number of organizations interviewed admitted to underestimating the time that value-based payment and care delivery implementation would take, and just how arduous organizational transformation would be. To that end, leaders in the organizations interviewed noted that it is important to set realistic expectations around what clinical outcomes, financial savings, and overall transformational progress can be made in a given year – and not to overinvest initially in costly resources. Instead, leaders suggested maintaining focus on the transformation process and the goals of value-based care and organizational culture change, which are to improve quality of care for patients and lower the cost burden of health care across the country.

“So basic IT is necessary, basic analytical capability is necessary, but people should resist the temptation to spend too much money and too much time worrying about that and keep their eye on the ball of making sure patients’ lives are affected...and clinical care is delivered differently.”

EXECUTIVE; LARGE, NATIONAL NONPROFIT HEALTH SYSTEM

Further, in order to achieve a malleable, successful, and sustainable value-based payment and care delivery infrastructure, many organizations emphasized the importance of obtaining continued input and feedback from staff and participants at all levels of the organization, and setting realistic goals.

“So basic IT is necessary, basic analytical capability is necessary, but people should resist the temptation to spend too much money and too much time worrying about that and keep their eye on the ball of making sure patients’ lives are affected...and clinical care is delivered differently.”

EXECUTIVE; LARGE, NATIONAL NONPROFIT HEALTH SYSTEM



“It really is just a lot of personal time and energy to talk about why we think this is important. And of course, eliciting feedback, and then trying to build the systems and supports that will make the walk the talk and the talk the talk as closely aligned as possible.”

EXECUTIVE; REGIONAL FEDERALLY QUALIFIED HEALTH CENTER

Governance Structure

Common Approaches

Similar to the balance needed within an overarching organizational structure, interviewees identified a need for both centralized and local governance structures that oversee the value-based portfolio. Importantly, this puts a premium on strong leadership structures and good communication between local and executive decision-makers. A number of organizations employ governance and management structures such as “dyads,” duos consisting of a clinician and an administrator who work jointly to make decisions, and/or governance structures consisting of a central board and market-level boards with similar compositions. These governance structures facilitate formal decision-making processes at both the market and central level that are critical to ensuring the success of complex, multi-pronged value transformations.

“The organization is organized around geographic regions led by a physician-administrative dyad. In this manner, services are tailored to meet the needs of each region, but the objectives that promote value-based care are consistent across all regions. We have dyads at every level, at the central level, at the regional level, and then in each delivery group.” If you’re going to get big, you need to have delivery groups around local communities in 5- to 10-mile radiuses that own that community and delivery system.”

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Using dyads to transform provider organizations: One partner organization’s perspective

In helping transform provider organizations into value-based systems, partner organizations have specific, evidence-based strategies that they utilize. For one organization, the dyad structure has helped meet transformation goals and objectives.

First, the dyad structure helps promote regional leadership while maintaining consistency across the organization from a centralized point of governance. In the organizations that this partner works with, the dyads consist of a physician lead and an operational lead who must work together to merge the clinical voice (objectives, experiences, outcomes) with the value-based payment management experience and broad organizational know-how of the “operator.”

The dyad structure also helps to promote adoption of a culture of value by holding regional dyads accountable for clinical results, quality metrics, and overall cost of care for that region. The partner organization helps to set up dyads at every level of care (i.e., central, regional, community care delivery centers). Each regional dyad coordinates with a high-risk dyad that oversees care for the high-needs population in that region, and then reports to the president in that specific market.



In addition, several organizations are subject to governance requirements under their value-based agreements with the federal government. Organizations that participate in federal value-based programs such as the Medicare Shared Savings Program are legally required to abide by governance requirements established by HHS. This includes establishment of certain boards and committees and appointment of specific leadership roles. In addition, Federally Qualified Health Centers (FQHCs) are subject to federally mandated organizational structures and governance features. For example, by federal mandate, fifty percent of the governing board of an FQHC must be made up of patients who receive their care at the organization.

Varying Approaches

While many of the organizations interviewed shared the common approach of a joint central/regional governance structure, there was wide variation in how much control was maintained at the central versus regional level. Some organizations relied primarily on centralized governance for decision-making, preferring to maintain consistency in program roll-out with as-needed modifications for different markets and patient populations. Others preferred to govern primarily at the market level, with centralized administrative and IT functions. A number of organizations were in the process of retooling their governance structures; some were creating new integrated governance structures to better facilitate shared learnings across markets. Payers in particular appeared to be consolidating programs and streamlining their governance structures:

“We are in the process of consolidating...And because it’s a large organization, we didn’t try and bring it all together at once. We’re slowly consolidating programs.”

EXECUTIVE; MULTI-STATE PAYER

The value in streamlining, this same payer noted, was consistency and reduced duplication across initiatives:

“We realized that we had to centralize some of the functions just so that we could do the same thing and do it well for all of our plans.”

For one provider organization, streamlining the governance structure was a top-down approach intended to promote consistency across markets and regions. However, while the organization streamlined their service lines and aligned them with specific care models, it maintained site-based management and accountability, allowing upper and middle management to develop value-based programs.

“The board doesn’t belong in operations. The board belongs in understanding our strategy, making sure we’re financially sound, making sure that our quality is positive, and that we have the right structures in place.”

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

“But naturally, you tend to get some siloing; you don’t get opportunities for as much natural coordination as you would like. Now what we’re doing is putting those pieces together to create a more integrated care coordination network for patients that we are accountable for across the entire system.”

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION



Lessons Learned

A number of organizations, especially those actively undergoing changes to their governance structures, expressed concern about information siloes resulting from complex governance and organizational structures. One hospital executive articulated it this way:

“But naturally, you tend to get some siloing; you don’t get opportunities for as much natural coordination as you would like. Now what we’re doing is putting those pieces together to create a more integrated care coordination network for patients that we are accountable for across the entire system.”

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION

Another lesson learned was the importance of developing governance structures and tools that are flexible, scalable and replicable to avoid unnecessary time and resources on restructuring. For example, developing an oversight process that is centralized but still allows for natural market variation. One interviewee noted that his organization had decided to seize momentum and build out its value business in flight, but in hindsight could have initially developed a more comprehensive structure:

“Our feeling was that the learning curve is not on the technical side. It’s on the market facing side and the market location side. And so we thought it was important to get going in each market. Now it would have been nicer if we had a better-established infrastructure that we had stamped out. Looking back, maybe we could have done more of that.”

EXECUTIVE; NATIONAL PROVIDER ORGANIZATION

Role of Executive/Clinical Leadership in the Cultural Engineering Plan

Common Approaches

As noted above, most organizations interviewed hold the assumption that a standardized vision of progress driven by experienced leaders is key to systematic culture change and value-based transformation. Leadership plays a pivotal role in the success (or failure) of most systemic transformations; in value-based transformation especially so because of the many complex moving parts and political perils of changing how providers practice and receive reimbursement for care. It is also important to acknowledge that executives at the organization and the clinical and managerial leadership in each market hold distinct, but often equally as important roles in facilitating transformation.

Executive Leadership

Among the organizations interviewed, strong leadership emerged as a unifying theme. In particular, interviewees almost universally stressed the importance of hands-on communication from the highest echelons of management to reinforce the importance of value-based care transformation. To that end, interviewees highlighted the need for visionary, dedicated, and experienced leaders to drive transformational change for an organization. While organizations noted the need for strong leadership and dedication to value at all levels of the organization, interviewees attributed early progress and success in value-based payment and care delivery to leaders at the top of the organization who were forward-leaning and steadfast in their pursuit of value.



Maintaining momentum also emerged as a key factor in successful transformation. Interviewees stressed the importance of leadership in keeping the organization focused on value, even after the initial “honeymoon” phase – and sustaining that momentum across a broad group of leaders, staff, and clinicians.

“Our next phase, continuous improvement, is to ensure that the leaders who have made the decisions, who are endorsing and supported the program, are able to spend time with the local leadership and governance people to convey that. And it’s not just their hospitalists or their hospital-based physicians. It really is quite a huge physician community that we’re talking about.”

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

Clinical Leadership

In many organizations, executive leadership worked together with market-level clinical leaders to develop and execute on a shared vision of transformation. According to one executive,

“The presence of local leadership in each geographic region has been critical. Ensuring that providers in each region felt they had a voice and had the opportunity to weigh in on decisions was essential to generating the desired level of participation and cohesion.”

EXECUTIVE; REGIONAL HEALTH SYSTEM

Just as leadership is critically important to value transformation, so is buy-in from all levels of an organization, and specifically local clinical leaders. Because value-based care requires input and coordination from many different operational and clinical areas, ensuring that leadership, staff, and clinicians are in lockstep on the importance of value and the steps to achieve it can mean the difference between success and failure.

“I think it’s because the COO and the director of care management came together, mapped out the work plan, and really just hit the pavement and communicated it to their staff, as well as through the medical hospitalists and the medical community-at-large.

Each of our markets fell on a spectrum of least engaged to most engaged. The data is indicative of that. The ones who are probably most engaged produced our best success stories. And the ones that were not as engaged did not see as much success.”

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

Varying Approaches

While strong leadership was a common theme among the organizations interviewed, these organizations varied significantly in leadership style. Some larger providers and payers took a more top-down approach, with a centralized vision and leadership style; this tended to be more popular in employed hospital/physician models and payer contracting approaches with direct lines of accountability and risk, and also among organizations pursuing specific federal models such as MSSP ACOs that require very explicit leadership structures. Others took more of a partnership approach through mechanisms such as joint venture arrangements; this approach was more prevalent among payers involved in co-branding value products with local health systems, and in consulting/technology companies that pair specific value expertise with provider organizations.



Among consulting partners, there was also significant variation in leadership style. Some primarily supported a model of “teach-to-independence,” with a goal of providing organizations with the leadership tools and resources necessary to eventually pursue value-based care on their own. Others employed a model of ongoing support, where they provide the leadership, tools, and resources (including personnel and technology) so provider organizations do not need to build them internally. Both approaches require strong communication and synchronous leadership between the partner organization and provider client to be successful.

“What we try to do is teach people to fish, teach organizations. Now, we have managed some care management programs for organizations, but we’ve done it on an interim basis. And then we help them build it. And we have all the templates, job descriptions, models, staffing ratios. And so we’ll go in and help them build their own care management program.”

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Another difference among organizations was the style of leadership communication. In provider organizations where staff and physicians are mostly employed, organizations placed strong emphasis on the importance not just of having a shared vision (as was a point of commonality among most organizations), but also of communicating and discussing that shared vision with clinical leaders to ensure that all levels of the organization are aligned around the shared goal.

“We do a lot of environmental work. And we talk about changing environment and we talk about the changing financing of health care. We go through the implications. We talk about changing provider compensation to align to these changes.”

EXECUTIVE, FQHC

For organizations with more of an indirect model, such as affiliated provider organizations and some payers, higher leadership communication appeared to be more concretely messaged around data. For example, one high-performing ACO leader encouraged physician participation through regular sharing of analytics and cost data. While these approaches are not necessarily mutually exclusive, messaging appears to be nuanced by leadership style, audience, and cultural environment.

Finally, there were multiple organizations interviewed that highlighted the need to not only coordinate with clinical leadership and incentivize the movement to value (either through a shared vision or sharing of cost and quality data), but also let those on the front lines of care delivery drive and design the care model.

“Traditional leadership structures, in which physicians were given a ‘seat at the table’ but not at the forefront of decision-making, proved no longer able to drive the kind of system redesign and sustainability necessary in this rapidly changing environment. Physicians involved in patient care saw firsthand the changes that would yield the largest benefits to patient care. Thus, it was logical to put them in positions to design, modify and approve process change.”

EXECUTIVE; REGIONAL HEALTH SYSTEM

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EXECUTIVE; REGIONAL HEALTH SYSTEM



Lessons Learned

One key lesson learned was the importance of establishing effective communication early on, particularly with vendors and partners. Especially when partner organizations are brought on early in the process to help providers transform, ensuring that there is clear direction from leadership and open lines of communication is essential. One participant articulated the cultural challenges of working with a new company, and the importance of finding a strong fit:

“The biggest lesson that we learned is making sure that the partnership is something that aligns as a fit, both culturally and vision-wise, because had it not been for that, I don’t know that we would have been as successful. Like any partnership, it was rough from the onset. You’re introducing new players, new stakeholders, and particularly with this engagement, with them being the conveners, and us being the episode initiators – so really had to be listening to each other and communicating well.”

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION

Another lesson shared among multiple interviewees was the underestimation of the length of time and resources required to truly shift an organization toward value. One health system recalled that it had explored options to acquire all inpatient and ambulatory care facilities in its network to improve the ability to drive value, but rejected the “go-it-alone” strategy due to time and resource constraints.

“Over time it takes everybody to be on the same page pushing the rock in the same direction. And, of course, that starts with senior leadership, executive and physician and non-physician. But it really takes a lot more knowledge and education and data and feedback and really getting everybody on the same page. My observation over time is that we’ve been very, very good and very successful in our old models of care. And part of this change really took time and education and continued reinforcement of the principles that we’re trying to achieve with it.”

EXECUTIVE; REGIONAL HEALTH SYSTEM

Finally, some organizations noted the importance of bringing patients more readily through the transformation process:

“I think bringing along the patients in this understanding and expectation is another piece that doesn’t always get front and center. We talk about being patient-centric, but many times we buffalo them with our own terminology and thought process so they’re not quite sure what we’re calling them for.”

EXECUTIVE; MULTI-STATE PROVIDER SYSTEM

Conclusion and Implications

The journey to value is complex, resource-intensive, and highly individualized. What works well in one scenario may not translate well to another. Although there is no “one size fits all” for value transformation, there are many lessons to be drawn from the experiences of organizations that have achieved success in value. The interviews described here, and the Dimensions of Health Care Transformation Framework on which they were based, provide a framework and knowledge base for leaders to draw from as they make strategic and cultural value decisions.



Recommendations for organizations embarking on the value journey

<p>Provider</p> 	<ul style="list-style-type: none">• Seek a balance of local and central oversight that is best suited for your organization. Build in a process to identify areas for optimization and quickly make changes.• Actively involve staff and clinicians in the process of organizational transformation. Offer appropriate education, resources, and outlets for expressing concerns.• Identify and engage value “champions” at all levels of the organization to maintain momentum for change. Ensure that leadership is actively connected across the organization to “connect the dots” between operational change and the end goal of value.
<p>Payer</p> 	<ul style="list-style-type: none">• Find opportunities to collaborate with high-performing providers. Form partnerships with organizations that have shown that they can already successfully take on risk for their patients.• Conduct market assessments to determine where value-based programs are most likely to succeed, and which programs will be most successful. Capitated arrangements, for example, may not be appropriate in markets where fee-for-service remains dominant.
<p>Partner</p> 	<ul style="list-style-type: none">• Meet your provider clients where they are. Not all organizations are ready to move to dual-sided risk arrangements or full capitation. Ensuring that clients are able to start where they are comfortable, even if it means participation in less risky arrangements, could mean the difference between failure and long-term success.• Make sure the partnership is a good cultural fit. Taking care to ensure that both organizations are aligned on values, goals, and expectations will save time, money, and stress.



Transformation to Value: A Leadership Guide

STRUCTURE AND INVESTMENTS

Who We Are

The **Health Care Transformation Task Force** (Task Force) is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change from volume of services to value of care, both for ourselves and our industry. To achieve this, we commit to have 75 percent of our respective businesses operating under value-based payment arrangements by 2020.

Introduction

The transformation from fee-for-service to value can be highly challenging, even for the most sophisticated organizations. The process of transformation requires strong leadership, well-defined strategic and operational plans, appropriate resources, and exceptional dedication at all organizational levels. Despite the importance of value transformation, there are few public resources that provide strategic guidance and examine broader trends in organizations' transformation experiences.

The Health Care Transformation Task Force (Task Force) has created a *Dimensions of Health Care Transformation Framework* (Framework) to help health care organizations assess their transformational maturity along the value-based payment and care continuum (Figure 1). The structure of the Framework provides the foundation for a series of interviews with provider and payer organizations that are deeply engaged in the transition to value. These interviews provide insight into the process of transformation: the decisions that organizations must make as they move along the value continuum, the options available to them and their consideration of alternative approaches, the rationale for particular decisions, and the subsequent results of those decisions.



Shared learnings related to changing organizational strategy and culture, as well as new structure and investments that organizations have put in place to facilitate their transition to value, are captured in this report. The report presents this information in a consistent way: (1) common approaches; (2) varying approaches; and (3) lessons learned.

The transformation to value is a long and risky process. There is no clear roadmap to success, and each organization has unique needs and resources. Further, it will not be possible to fully assess the impact of the changes that organizations have made for several years yet to come. Rather than identify industry best practices for delivery system change, the approaches described below illuminate a broader plan for success. In some instances, there is significant alignment about the path forward; in others, the organizations interviewed diverge in their approaches. Together, these findings paint a detailed and diverse picture of the path to transformation to help guide organizations as they embark on their own journey to value.

Structure and Investments

In the second dimension of the Framework, Structure and Investments, the Task Force identified three main influential components: (1) Infrastructure; (2) Workforce; and (3) Business Focus Areas.

<i>Dimensions</i>		<i>Concept</i>	<i>Execution</i>	<i>Sustainability</i>
Structure and Investments 	<i>Infrastructure</i>	What infrastructure is needed to support the value-based model of care? How is infrastructure assessed, built, and maximized? What are the capital needs and available financing resources?		
	<i>Workforce</i>	What skills, competencies, and roles are needed to support the new models of care delivery? How are staff recruited or re-trained to incorporate new staff roles and functions? What are the performance metrics?		
	<i>Business Focus Areas</i>	How are initial payment models or care delivery models identified? How are distinct payment models/care delivery models integrated? How is consumer engagement planned and achieved?		



Structure and investments are critical to the transformation journey because they encompass the physical infrastructure and human capital requirements needed to successfully build a value-based delivery system. Finding the right balance of resources to invest in can be extraordinarily challenging, especially for organizations that are new to value-based care. Many of the executives interviewed discussed the importance of identifying highly skilled, experienced leaders to assist with the transition process. With experienced stewardship, organizations can successfully stand up their value businesses and invest intelligently in infrastructure and resources. Below, high-performing organizations discuss their own experiences in building value-based care structures.

Infrastructure

Common Approaches

Substantial investment in infrastructure, especially data analytics and reporting, was a common theme among surveyed organizations. While most began their value transformation journeys with some technological competency, many reported making significant additional investments.

“We’ve really been able to build analytics engines and build an IT staff and have robust network systems and call centers and care management programs, and do the kind of work that we now do in the ACO frame. If not for the resources, I don’t know that we would be ready to do it.”

EXECUTIVE; FEDERALLY QUALIFIED HEALTH SYSTEM (FQHC)

Many organizations highlighted the value of streamlined electronic health records, and the importance of interoperability in coordinating care and collecting data for evaluation. A few organizations mentioned building analytics infrastructure that can support proactive versus reactive care. Others also discussed the importance of ensuring tight alignment between care management and IT infrastructure, and the value of securing and using robust data sources to inform clinical and administrative decision-making.

A large, multi-state health system makes strategic investments in data analytics

For one health system, investment in data analytics has proven critical to its value transformation. The organization has redefined how it uses analytics, expanding it from just an IT function to a more holistic, cross-departmental initiative, and shifting from a reactive to proactive approach to patient needs. One executive expressed a goal of becoming the “Netflix of health care” by anticipating patient needs before they arise, much like the media company identifies consumer viewing patterns and proactively tailors its entertainment accordingly.

Such a proactive approach is becoming more common among leaders in value-based care, but is still new in the world of volume-driven fee-for-service medicine, where patient needs are addressed reactively. The health system is currently working directly with community providers to enhance its proactive population health strategy.



Varying Approaches

Although most organizations emphasize strong IT and care management infrastructures, there is variation in who is responsible for developing and implementing them. Payers are more likely to build out their IT capabilities in-house, or have an internal effort dedicated to finding and assembling “best-in-breed” solutions. Some payers have developed infrastructure exclusively for their value-based care initiatives, while others have built upon existing capabilities, such as claims analytics, in other lines of business. One payer has partnered extensively with individual providers to develop market-specific value-based care initiatives, combining resources from both payer and provider to fill in knowledge and infrastructure gaps.

How are organizations developing their value infrastructures?	
<p>Provider</p> 	<ul style="list-style-type: none"> • Hiring experienced leaders and staff to design and build out their own infrastructures, contracting with one or more vendors for specific capabilities (i.e., EHR) • Partnering with a consultant to: <ul style="list-style-type: none"> ○ Conduct needs/capabilities assessments ○ Build out IT infrastructures, oftentimes implementing integrated platforms that can integrate various data sources such as EHRs, claims data, and admissions/discharge feeds ○ Design and create care management leadership structures and delivery teams – sometimes using staff from partner organizations • Working collaboratively with a partner/consultant to provide expertise and guidance on a particular program or set of programs, but retaining primary control over development and oversight
<p>Payer</p> 	<ul style="list-style-type: none"> • Building from existing internal resources, such as IT, analytics, and care management functions • Outsourcing care management to contracted provider organizations • Creating “spinoff” entities that have consulting, IT, and care management functions (note: some of these spinoffs are being re-incorporated into their parent companies in order to streamline financial and organizational management) • Creating joint venture partnerships with health systems that already have value-based infrastructures in place

Some health systems and provider organizations are collaborating with third-party partners to build out their infrastructures, preferring to bring in outside expertise and resources – at least initially. In some business models, third-party organizations help set up the initial IT, care management, and governance structures with the eventual goal of fully transitioning responsibility to the provider. In other models, partner organizations will provide the infrastructure, including ongoing data analytics and care management support, for an initial implementation fee and per member/per month cost. Other health systems have decided to pursue value transformation on their own, preferring instead to hire and build out their own infrastructures. The organization’s strategy depends on several variables such as timeline, resources, baseline technical and clinical competencies, and culture.



Another variance is the process by which organizations incorporate new learnings and programs into their infrastructure. Some interviewees, including a few large payers with broad books of value business, indicated that they were creating rapid-cycle innovation processes to allow new programs to be tested, evaluated, and rapidly discontinued if results did not show improvement. Large health systems are adopting similar processes to identify key learnings and innovations in individual markets, then scale and implement those innovations across other markets.

“We essentially have groups that meet and sprint every six weeks, so they’re looking at data on how their population is performing, their members are performing, and then they are writing stories and developing innovations to better prove the outcomes for that population. They then implement those, and review progress. They demo their innovations to the company writ large, and then they sprint again.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM

Other interviewees, especially smaller organizations with fewer value initiatives, do not currently have the infrastructure to support formalized rapid-cycle testing processes, or may be participating in government value initiatives that are not as conducive to rapid-cycle innovation.

Lessons Learned

Multiple providers emphasized the importance of carefully assessing how much the organization needs to invest in infrastructure before moving forward with value-based care, especially with competing attention from many different vendors and services. While there was broad consensus on the importance of building out supporting infrastructure, some sounded a note of caution on investing too heavily too quickly in technology without fully understanding how to most effectively allocate resources.

“There have been high expectations that technology is the solution, that there have to be nice big data tools that integrate large swaths of information to do accountable care effectively. And some systems have gone in lock, stock and barrel into that space. Others have not. We’ve struggled not to rush out and see technology as the solution and look for the next shiny object of the day. Rather, we’re trying to be effective in delivering care. But it’s easy to spend money on infrastructure. It’s hard to find the sweet spot of where that effective use of that spending can help you get to the same achievement in engaging your patient population, which is your end game.”

EXECUTIVE; MULTI-STATE PROVIDER SYSTEM

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EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM



Workforce

Common Approaches

Interviewees almost universally emphasized the importance of a highly skilled workforce, especially individuals with prior experience implementing successful value-based programs and those with sophisticated technological and data analysis skills. Health systems identified the challenges of creating cultural and structural change in organizations where the status quo is held as the standard. These leaders highlighted the value in importing talent from outside the organization, and even outside the provider sector, to help catalyze momentum for change:

“If you don’t have it, you need to import the technical know-how. It has been difficult for people who have been in standard care delivery models, hospitals or even physician practices. It’s hard for them to understand the population health approach or the episode approach, frankly.

It’s important to get people with good experience, often times from managed care plans or people who have done extensive work across the continuum of care management activities.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM

Where skill gaps remain, especially within the clinical workforce, members noted the need for retraining. Much of the education and retraining focuses on the integration of care elements such as social services and care management, as well as training on assessment, workflow, and reporting tools.

Finding staff, leaders, and clinicians who are culturally aligned with the mission of the organization and the value transformation is critically important. Since transformation must occur at all levels of the organization, misalignment in goals and motivation has the potential to sabotage long-term success.

Skill types sought in value-based workforce (by both payers and providers)

Organization Type	Value Initiative
Leadership	<ul style="list-style-type: none"> • Previous experience running value-based programs • Experience working in both clinical and managed-care environments • Ability to motivate/engage all organizational levels around transformational change
Clinical	<ul style="list-style-type: none"> • Flexibility/adaptability to organizational transformation • Ability and willingness to collaborate with multifunctional teams (i.e., care management, primary care, social services, and behavioral health) • Literacy in tracking/interpreting data and incorporating into continuous improvement cycles



Skill types sought in value-based workforce (by both payers and providers), Cont.

IT	<ul style="list-style-type: none">• Sophisticated data analytics and reporting capabilities• Ability to integrate data from multiple sources
Other Staff	<ul style="list-style-type: none">• Actuarial and financial modeling experience• Population health experience, particularly in care management• Literacy/experience with federal and state program regulations• Experience with value-based contractual negotiations (particularly important for providers)

Varying Approaches

Organizations differed in how they teamed and collaborated on new value initiatives. Payers and some providers are more likely to hire and train staff in specific areas such as data analytics, actuarial science, and reporting. For businesses with a heavy focus on technology, hiring highly capable and experienced technical workers is prioritized. For other organizations, finding nimble workers who can operate in a multi-disciplinary, matrixed environment is paramount.

“People just bring different expertise to the table. We’ve turned the concept of traditional roles on its head. We’re focused more on the outcomes – who has got the bandwidth to do something? I don’t care what your title is. We’ll fit the functionality to the competency.”

EXECUTIVE; MULTI-STATE HEALTH SYSTEM

Lessons Learned

One common observation was that despite culture and skills training, not all staff or clinicians have the ability or desire to engage in value transformation. Medical leadership can pose both intentional and unintentional roadblocks if they are opposed to change or simply lack the necessary skill sets to effectively guide their staff and fellow clinicians. In these instances, organizations emphasized the importance of identifying these skill/value discrepancies early on; employed health systems in particular should expect a natural attrition rate for significant value transformations. Ensuring that providers have ample opportunity for training and education can be critical, however, especially in markets where there is a shortage of primary care resources and/or providers are affiliated rather than employed by the health system. In these markets, organizations must be mindful to build support systems for providers to help them move toward value, and to offer appropriate financial incentives for strong performance. However, even with a highly motivated/competent workforce and excellent leadership, the cultural transformation to value can take a vast deal of time, resources, and patience.



Business Focus Areas

Common Approaches

Nearly all organizations and professionals would agree that there is no one-size-fits-all approach to the transformation to value. Just as key operational changes and decisions (e.g., governance, workforce, infrastructure) are based on a variety of factors and characteristics, the overarching decision around which value-based payment and care delivery models to pursue is predicated on the needs of an organization's attributed population as well as a variety of other components such as cost-saving potential, organizational ethos, potential return on investment, organization size, provider type, type of partnerships available, and a desire to gain experience in certain value-based models.

"Our original intent in joining the MSSP program had less to do with any sort of anticipated new revenue stream, and much more to do with our first venture into really starting to manage the total population's health."

EXECUTIVE; FQHC

It is key, therefore, that an organization assess its potential for success under a variety of models and align that with the clinical needs of their patient population and the factors described above to ensure the best possible care. The organizations interviewed shared this sentiment:

"The biggest thing is scope. With each market, we are really running tandem assessments of what the market dynamics are, the fit, the type of value-based initiative or demonstration that makes sense."

EXECUTIVE; MULTI-STATE HEALTH SYSTEM

In addition, most organizations are not homogenous institutions. Therefore, the factors and assessment described above often lead to an organization investing in and pursuing a variety of value-based models within a single organization. In doing so, organizations must determine how much, or how little, to integrate these efforts, which impacts discussions of structure and governance, particularly for large organizations.

Varying Approaches

Given the variability in organizations and populations, it is not surprising that the organizations interviewed varied greatly in the type and quantity of models pursued. This difference was most stark, however, when comparing across organization type (i.e., payer vs. provider). In order to accommodate the characteristics and complexities of a variety of markets, payers appeared to be involved in a wider array of value-based payment arrangements than were providers.

"We actually have a high degree of flexibility in each of these models. One PCMH program may operate materially different than a different one, and one ACO product may have materially different terms than another one. And that's by design, because the providers are on an evolutionary cycle of their own, and we're trying to meet them where they are and then advance them along the continuum."

EXECUTIVE; LARGE NATIONAL PAYER



There are also differing opinions about the need for, and utility of, varying value-based models. In particular, organizations differed in their use of bundled or episode-based payments to augment their accountable care or shared savings arrangements.

In addition to the specific models chosen, organizations also differ in their recognition and definition of progress. On the one hand, some organizations believe that in order to “move the needle” at all on improving quality of care while lowering costs, drastic changes must be made to the current models of payment and care delivery. While there is recognition that transformation takes time, these organizations believe in the need to act quickly, invest greatly (upfront), and promote change by transforming entire organizations at once. On the other hand, some organizations believe in the power of small, incremental change. They note that transforming entire organizations all at once requires an investment that is too large, too risky, and possibly doomed to fail. As such, these organizations welcome any and all change, no matter how small, and have invested in a variety of programs and processes that will slowly transform their organizations over time. This contrast is captured by the following pair of quotes:

“If I wanted to do a little experiment and dip my toe in the water, I’d do a couple of bundles, or maybe an ACO here or there. If I want to get on the road to a system that’s transformed to be delivering that kind of care, I’ve got to get as much of our businesses into payment vehicles that support that as we can. And that’s the rationale.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM

“The best way to assess [transformation change] is not in the grand scheme, but in the small, incremental changes where the improvement is made.”

EXECUTIVE; FQHC

Lessons Learned

The transformation to value is a complicated endeavor that lives and dies on the ability of organizations to successfully negotiate, manage, and execute value-based contracts. As noted above, this requires organizations to recruit individuals skilled in the intricacies of value-based contracting, and/or retrain individuals accordingly. Many of the organizations interviewed agreed that along the way, they have learned to use caution and foresight in contract negotiations. One of the key reasons for this is that under shared savings models, financial returns will not be realized within short-term contract cycles. As a result, organizations have recognized the need to plan accordingly for the long-term, both in terms of investments and in terms of anticipated savings over time. The use of appropriate due diligence and caution in value-based contracting was also recognized as essential in helping organizations fully understand the financial implications of their investments.

Another lesson learned by organizations was that individual market dynamics make it difficult to implement change to the same degree, or on the same timeline, for every market in which an organization is invested. While nationally based organizations have a broad view of transformation efforts and market dynamics across the country, these organizations have also seen that achieving broad change across the national market is not a practical or achievable goal. Instead, organizations have prioritized investment in specific markets, tailoring their efforts and catering to local market dynamics and populations in order to achieve greater success in transformation.



A national payer finds success in targeted partnerships

When it comes to defining success in value-based care, one national payer has experienced firsthand the challenges of deciding how to invest in value across markets. The organization started out with plans to have a broad, national value footprint, but eventually recognized that certain markets were not ready to support the change. The decision to scale back its initiatives to certain markets is a reflection of the payer industry’s desire to evolve upstream into more direct member engagement models such as accountable care organizations that encourage providers to take on more risk. Noted one executive,

“I think we’ve gotten increasingly focused on...being deeper in fewer markets now than we’ve been in the past...And we’re looking to grow membership and market share in those kind of markets and put a lot of resources in those spaces, as opposed to continuing to find more and more markets to spread our resources.”

Conclusion and Implications

The journey to value is complex, resource-intensive, and highly individualized. What works well in one scenario may not translate well to another. Although there is no “one size fits all” for value transformation, there are many lessons to be drawn from the experiences of organizations that have achieved success in value. The interviews described here, and the Dimensions of Health Care Transformation Framework on which they were based, provide a framework and knowledge base for leaders to draw from as they make strategic value decisions on structures and investments.

Recommendations for organizations embarking on the value journey

Provider



- Engage in robust internal strategic planning before committing to a value-based strategy. Determine what will be necessary to build up-front versus what can be developed out in the future.
- Consider partnering with a consultant/technology firm that has significant experience helping other organizations develop their infrastructures, but be mindful of what can be built in-house versus what must be outsourced.
- Hire wisely. Seek out individuals with prior experience in value and/or specific skill sets that are directly relevant to the value business.

Payer



- Consider forming strategic partnerships with specific provider organizations in certain markets, instead of broadly pursuing value-based arrangements that may not effectively move the needle on value-based care (such as pay-for-performance agreements).



Transformation to Value: A Leadership Guide

OPERATIONS AND ACCOUNTABILITY

Who We Are

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Introduction

Transforming an organization from volume-driven fee-for-service to value can be a complex and challenging experience. The transformation process requires effective leadership, strong strategic planning, sufficient operational resources and dedication at all levels of an organization. Despite the importance of value, very few public resources exist to guide decision-makers in their transformation journey and provide insights from organizations that have successfully transitioned to value.

The Health Care Transformation Task Force (Task Force) has created a *Dimensions of Health Care Transformation Framework* (Framework) to help health care organizations assess their transformational maturity along the value-based payment and care continuum. The structure of the Framework provides the foundation for a series of interviews with provider and payer organizations that are deeply engaged in the transition to value.

These interviews provide insight into the process of transformation: the decisions that organizations must make as they move along the value continuum, the options available to them and their consideration of alternative approaches, the rationale for particular decisions, and the subsequent results of those decisions.



Shared learnings related to changing operational accountability are captured in this report. The report presents this information in a consistent way: (1) common approaches; (2) varying approaches; and (3) lessons learned.

The transformation to value is a long and risky process. There is no clear roadmap to success, and each organization has unique needs and resources. Further, it will not be possible to fully assess the impact of the changes that organizations have made for several years yet to come. Rather than identify industry best practices for delivery system change, the approaches described below illuminate a broader plan for success. In some instances, there is significant alignment about the path forward; in others, the organizations interviewed diverge in their approaches. Together, these findings paint a detailed and diverse picture of the path to transformation to help guide organizations as they embark on their own journey to value.

Operations and Accountability

In the third dimension of the Framework, Operations and Accountability, the Task Force identified three primary components: (1) Operational Alignment; (2) Financial Incentives; and (3) Quality Measurement. This dimension addresses the key components for ensuring that value-based transformation is successfully executed upon.

<i>Dimensions</i>		<i>Concept</i>	<i>Execution</i>	<i>Sustainability</i>
Operations and Accountability 	<i>Operational Alignment</i>	How are the objectives of value-based care managed across multiple operational service lines? Who is responsible for operational alignment planning and its execution? What training activities are necessary for success?		
	<i>Financial Incentives</i>	How are operational and clinical managers incentivized to ensure movement towards value-based care goals and objectives? Who is responsible for reviewing performance of the operational and clinical managers?		
	<i>Quality Measurement</i>	How does the organization evaluate and measure progress on quality improvement? Who is responsible for collecting, reviewing and acting upon quality measures?		



Operational Alignment

Common Approaches

Many of the participants use centralized leadership structures to ensure alignment of value objectives across multiple lines of business. These centralized structures promote structured communication channels and scaling of shared learnings across markets and lines of business.

Several organizations, especially those with highly articulated leadership structures and/or those who had recently undergone reorganization, indicated they had specific processes to identify successful innovations and scale those across lines of business and markets.

One regional payer organization has a dedicated value division for developing and sustaining a competitive marketplace advantage. The division is responsible for controlling benefit costs, addressing the quality of care delivery, and maintaining access to a broad provider network. The division's leadership team is comprised of stakeholders from various departments such as care management, contracting, and product development. It is jointly responsible for ensuring that planning activities are aligned across service lines, corporate initiatives, and ultimately support the company's value objectives.

One large technology and consulting firm servicing providers employs a standardized structure across each line of business (such as accountable care organizations and Medicare Advantage). Each line of business has an executive leader who is responsible for overseeing profits and losses for that particular line of business. The executive leader is responsible for convening market-level leaders to ensure that value-based objectives and financial targets are being met, and identifying processes and solutions that can be scaled across the entire line of business. This approach was developed after the company's leadership identified gaps in communication and duplication of efforts across markets.

"The executive lead...must have a profit and loss statement (P&L) for each line of business. The revenue side of the P&L must have a bottoms-up build to understand what activities are going to drive the revenue side of value-based care."

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Another common theme among interviewees was the importance of alignment, accountability, and shared decision-making at various levels of the organization. Ensuring that employees and affiliated providers are held accountable for enabling the success of value-based care initiatives was highlighted among nearly all organizations. One community health organization's leadership engages its clinical teams in daily huddles, and uses pre-visit planning documents to ensure coordination and appropriate execution. The organization is in the process of rolling out an updated leadership and decision-making structure across clinical, financial, operations, and patient experience teams in order to ensure that their value-based care programs perform optimally.

"The process has really tested us, as we've really changed the organizational structure, and are just beginning to roll out the new decision-making leadership structure. But it does take key leadership in clinical, financial, operations, and patient experience, and leaders to bring them together as our cabinet, where key decisions on leadership, resource allocation, business restructuring, and strategic direction are answered. This is a different way for us."

EXECUTIVE; FEDERALLY QUALIFIED HEALTH CENTER (FQHC)



Varying Approaches

The degree of centralization and operational alignment varied by organization. Some companies retain most of the decision-making power at the market level, and thus have less formal operational alignment processes across the broader organization. Others prefer to consolidate functionality at the corporate level. The size and type of the organization (i.e., community versus national, provider versus payer) also correlates with the degree of operational alignment and decision-making structure.

Many of the national payers and larger health systems have, or are in the process of moving toward, greater centralization of their value-based business initiatives. For payers, this is primarily driven by the need to standardize and optimize a portfolio of various value-based care programs. One national payer initially spun off many of its value-based initiatives into a separate company, but later decided to re-consolidate within the parent company. The reconsolidation helped the company better standardize processes, create efficiencies of scale, and reduce duplicative business structures.

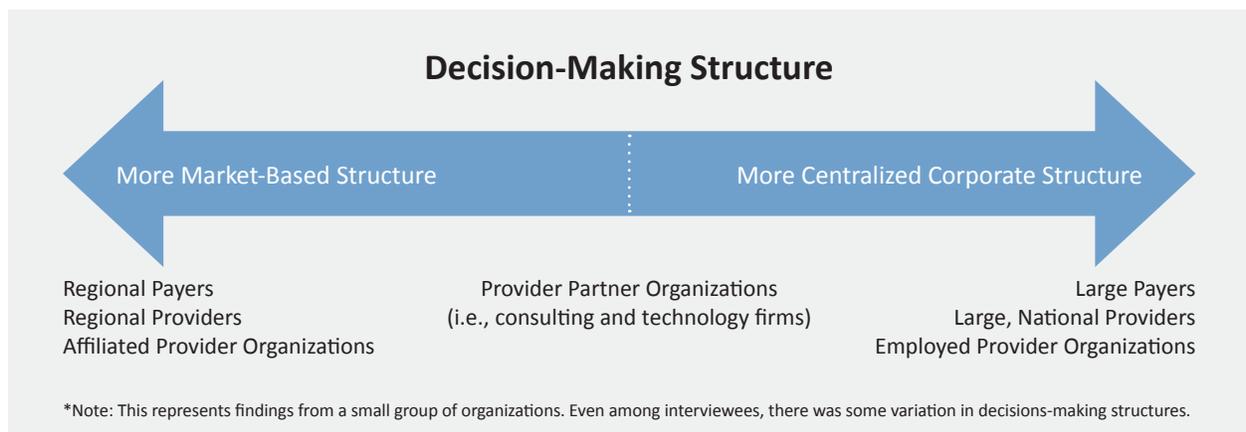
“We do expect people to follow and use standardized approaches and standardized infrastructure, although because we had people starting at different times, and because we’ve had people join us after they’ve already started doing some of these things, we end up with people in different states and stages. And we haven’t got everyone operating on the same infrastructure at this point, despite that principle. But we do expect...everyone to report using standardized metrics so that we can compare effectiveness across the organization.”

EXECUTIVE; LARGE NATIONAL PROVIDER ORGANIZATION

Many of the smaller provider organizations interviewed have more blended structures of local and corporate decision-making, and in some instances more informal operational alignment structures. The degree of formality also varies by the percentage of providers that are employed versus affiliated. For some provider organizations, legal and compliance requirements for initiatives such as the Medicare Shared Savings Program (MSSP) help drive alignment across other lines of business. One local organization comprised of affiliated provider groups uses the Triple Aim as a basis to align and operationalize its value objectives.

“Our objective is the best value-based care. We do it at the operationally appropriate cost levels with the best quality possible, with excellent engagement of the patient. So, I just follow the principles. I operationalize the principles of the Triple Aim.”

EXECUTIVE; REGIONAL PROVIDER ORGANIZATION





Lessons Learned

One common lesson learned was the missed opportunity to connect more effectively with providers, particularly specialists, who may fall outside the direct sphere of influence for value-based care. Since many specialists and provider groups contract with multiple systems, maintaining active engagement and participation can be challenging – let alone ensuring coordination across several value initiatives. One administrator for a large health system stated,

“At the end of the day, the biggest struggle we’re hearing from the physician offices is that they’ve got umpteen quality metrics across the board, whether that’s from CPC+, or they may be part of PCMH and all the stuff of their own accord. They also have hospital initiatives and these value-based initiatives. It’s very confusing.”

EXECUTIVE; MULTI-STATE HEALTH SYSTEM

Finding better ways to coordinate across value initiatives with these contracted groups was a desire expressed by several organizations.

Financial Incentives

Common Approaches

Nearly all the organizations surveyed reported that they use gainsharing as financial incentives for providers. Despite variations in the type of value based payment program, nearly all use some form of gainsharing payment to incentivize participation and adherence to metrics.

“If the money is not sufficient enough for the providers, they may be more resistant because we’re asking them to do a lot of work. And there may not be a lot of upside for them in the request. We always have to be mindful of the total available resources at our disposal.”

EXECUTIVE; FQHC

Varying Approaches

Although financial incentives are common among interview participants, the amount and type of incentive varies significantly. Payer organizations contracting directly with physicians and/or physician groups in value-based arrangements typically offer base payments with additional incentives based on adherence to set quality and cost metrics. For more advanced provider-payer risk-sharing arrangements, such as accountable care organizations and/or joint venture arrangements, incentive payments may not be distributed to the provider directly from the payer, but rather rely on the provider organization to determine how best to disburse. Several payers noted that they are increasingly involving providers in the development of financial incentives, and/or encouraging providers to tailor incentives themselves.



Across provider organizations, there is significant variation in how clinicians and operational leads are financially incentivized. In many large systems, especially those with multiple value programs, financial incentive structures can differ based on the program and line of business. For many systems, financial incentives can be dynamic; for example, an organization can provide incentive payments through an Accountable Care Organization (ACO) even if it did not achieve savings in a particular year, but may change the structure over time. Many of the larger provider systems also employ structures where departments rather than individual clinicians are incentivized. Organizations may also experiment with the metrics used to calculate incentive payments.

One provider sounds a note of caution in population health measurement

For one national provider organization, tracking population health has been a deliberate exercise. Rather than immediately tie physician financial incentives based on a set of new metrics, the organization is carefully tracking the metrics to determine their reliability before incorporating them into performance assessments.

“We thought about using some of the more obvious population health metrics. We are tracking the 75 percent of total payments in value-based arrangements by 2020 goal. And we have a couple of metrics that we measure on a quarterly basis, such as the percentage of our care that’s delivered under the contracts, as well as the percentage of our contracts which have a Triple Aim reimbursement model in place.

We are tracking those metrics now. We don’t feel like we have enough competence in how to use them. We’re in a period of trying them out to see how they perform on those metrics. We’ll make decisions later about whether or not to wrap them into our incentive plans.

Similarly, we’re monitoring total cost of care for those populations, and we’re monitoring the savings produced under our APMs, to see if they will be useful to use in our incentive program in the future.

Right now, we felt like they were not reliable enough so we didn’t want to put them into the incentive plan yet until we knew more about how they perform.”



Lessons Learned

Though financial incentives were identified as important, some participants noted that they were simply not enough alone to change operational and clinical practice patterns.

One national payer organization reflects on its early failures with financial incentives

“I’d say the financial incentives are critically important, but wholly insufficient at changing behaviors.

If you think about what we did in the ’90s as an industry, we basically stopped at the financial incentive. We didn’t have the technology platforms. We didn’t have the clinical insights. We didn’t have any of the behavioral change expectations. We didn’t have the benefit designs. There were a lot of things we didn’t have in the ’90s.

And looking back, it was naïve to think this way. But industry’s thought was to move to capitation and put the financial incentives on the providers’ backs to manage. These are smart organizations. These are good businesses. If you give them the right incentives, they’ll figure it out, right? That was the basic strategy.

By the late ’90s, that came crashing down. If you talk to any providers who lived through those periods and took on risk, their mantra was, ‘I’ll never do it again because I got burned so badly.’

And the reality was that they bought a lottery ticket. They bought an incentive with no investment in changing their process and no investment in changing their behavior. Ultimately, we saw no change as a result. It was unsustainable. There were winners and there were losers. But it was more random than managed.

What’s changed is that we’re still certainly doing a lot of the models that were around in the ’90s and even earlier. Capitation has been around since the ’80s. We’re still employing a lot of those financial incentives. But we’ve learned the hard way, through the ’90s, that it’s going to take a whole lot of other investment after the signature. I think the hardest work is after the signature.”

While financial incentives were perceived as not sufficient alone to change behavior, some also noted that providers may be unwilling to take on the additional work of value transformation if the financial incentives are not strong enough – or if they are not paid quickly enough. One provider organization shared its frustration with the limitations of paying incentives that are partially based on claims data, as this data is generally subject to a lag that can extend well into the following year. This creates a natural delay in incentive payments, which can subsequently decrease provider momentum on value.

“You want to be able to tell people on January 1st, ‘this is how we did last year, this is where we are.’ But because a lot of the measures are related to claims, you don’t know where you are. There are definitely timing issues associated with value-based care.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM



Quality Measurement

Common Approaches

Interviewees roundly emphasized the importance of data analytics and reporting capabilities for accurate and timely quality measurement. For most organizations, quality reporting and analytics are streamlined through one or a few centralized departments, with feedback processes in place to ensure that clinicians are receiving and using the information to make meaningful performance improvements. One provider executive highlighted the difference in quality reporting for traditional fee-for-service versus its value programs:

“In the traditional hospital world, we have a unified clinical organization that works closely with our physician and nursing leadership to track and drive improvement on hospital quality measures that includes hospital-acquired infections, hospital-acquired conditions, and patient satisfaction rates. We have a whole traditional system in place to do that work for our acute sites.

In our value-based payment world, those folks are also collecting information around the Medicare value-based payment indicators and driving programs to improve those measures across our hospitals and in our doctors’ offices.

For our alternative payment models, we’re monitoring a variety of Medicare standard indicators. We’ve put corporate systems in place to provide gap closure reminders, et cetera. Those go out to our ACOs, and then the ACOs drive their local performance improvement opportunities through relationships with their participating physicians.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM

While providers emphasized the importance of streamlining many different quality metrics and creating appropriate feedback loops with providers, payers noted a broader movement within the insurance industry to standardize the metrics they require providers to report on:

“We’re increasingly driving towards the industry benchmarks and away from our own unique set of very customized quality measures. We’re trying to tie to what many other organizations have done or are doing. And increasingly, those are getting more consistent across the industry.”

EXECUTIVE; LARGE NATIONAL PAYER

Many organizations also emphasized the importance of engaging clinicians in the reporting process, and ensuring that providers are required to report on the most meaningful metrics.

“Most important is that you’re willing to engage clinicians in these efforts. They need to see that their work is clinically meaningful. The earlier generation of measures were very process-oriented. That’s not a good way to engage clinicians. It’s really got to be a limited number of meaningful measures with consistency across payers, so you’re not feeling like you’re just chasing a hundred measures.”

EXECUTIVE; REGIONAL PROVIDER



Varying Approaches

While most organizations centralize their quality reporting, there is still significant variation in the type and quantity of metrics collected. Smaller provider organizations, for example, may collect and report data on a single program such as MSSP. Larger provider organizations with many different value initiatives could be required to report on many different metrics for both public and commercial payers. Metrics can also vary significantly by line of business, even though (as described above) commercial payers are working to streamline their own metrics to ease the reporting burden for providers. The relative maturity and success of quality initiatives can also vary significantly by organization.

Comparison of Quality Approaches	
Value Initiative	Quality Reporting Requirements
Medicare Shared Savings ACO	Reporting on a set of standardized metrics across the following topics: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population ¹
Medicare Bundled Payments for Care Improvement Initiative	Reporting on designated metrics according to the type of bundle selected; metrics include risk-standardized complication rates, HCAHPS survey scores, and patient-reported outcomes data ²
Commercial ACO	Varies by organization; can include topics such as access to care, chronic disease management, utilization, patient satisfaction, and preventive care
Other Commercial Value Contracts	Varies by organization

1 <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf>

2 <http://www.aha.org/content/16/issbrief-bundledpmt.pdf>

Lessons Learned

Physician burnout from over-measurement, and the importance of identifying a parsimonious set of quality metrics, was one major theme among interview participants. Many providers stressed the importance of ensuring that clinicians are not simply asked to “check the box” on quality metrics, but are instead asked to incorporate the most meaningful metrics into their clinical processes.



One community health organization identified physician burnout as a catalyst for the organization to move from the Triple Aim to the Quadruple Aim, which addresses work life improvement for clinicians and staff. The issue, one executive argued, is relevant from both a human and business perspective; when providers are unhappy and burned out, they will quit. Since the organization participates in the Medicare Shared Savings Program as an ACO, its financial performance is linked to the number of members who are attributed to the program. When providers leave the organization, they will take their patients with them, resulting in lower ACO membership.

“We are trying to move from the Triple Aim towards the Quadruple Aim. There is a lot of discussion around primary care provider burnout and how we deal with it. If we have providers that are unhappy and burnt out, and since attribution is tied to the physician, we should be very mindful that having happy employees is a good thing for everyone, but also on the core business side that losing people has a big financial consequence.”

EXECUTIVE; FQHC

Several providers also noted the level of difficulty with the process of aligning metrics across payers, with some citing less-than-optimal levels of success, especially when incorporating into a patient-centric care model:

“We don’t separate metrics by contract because we don’t believe that physicians can treat patients differently. Our whole goal has been to treat everybody the same along the same population health philosophy, with person-centric care, and have the same data regardless of payer. One area we’ve been minimally successful in is trying to align quality measures, because we just don’t think it’s tenable to ask our providers to manage people differently based on the contracts they’re in.”

EXECUTIVE; MULTI-STATE HEALTH SYSTEM

Conclusion and Implications

The journey to value is complex, resource-intensive, and highly individualized. What works well in one scenario may not translate well to another. Although there is no “one size fits all” for value transformation, there are many lessons to be drawn from the experiences of organizations that have achieved success in value. The interviews described here, and the Dimensions of Health Care Transformation Framework on which they were based, provide a framework and knowledge base for leaders to draw from as they make strategic value decisions regarding operations and accountability.



Recommendations for organizations embarking on the value journey

<p>Provider</p> 	<ul style="list-style-type: none">• If planning to engage in multiple value initiatives, consider establishing a single department or defined organizational structure to share and scale learnings across lines of business and markets.• Ensure adequate investment in data and reporting capabilities so providers can accurately track their quality performance. Provide appropriate training for providers on how to use quality reporting to drive continuous improvement.• Carefully consider how to tie financial incentives to performance. Are providers going to receive incentives even if the organization does not meet its overall payer performance targets? Will you use evidence-based quality metrics to determine payments?
<p>Payer</p> 	<ul style="list-style-type: none">• Consider streamlining quality metrics across contract types and industry standards to minimize physician reporting burden and encourage better performance.• Ensure that physician financial incentives are directly tied with clear standards for performance evaluation and improvement. Encourage physician participation in arrangements that result in clear elevation of value or promote a path to value (such as accountable care organizations), rather than continued participation in lower-value constructs such as pay-for-performance.
<p>Partner</p> 	<ul style="list-style-type: none">• Work with provider organizations to streamline reporting and analytics as much as possible, and appropriately train providers to effectively use these resources. Refrain from overselling expensive technology solutions when not needed/ appropriate.• Optimize internal organizational structures to ensure that shared learnings are identified and replicated across markets. Identify one or more “point persons” who will oversee the process.



Transformation to Value: A Leadership Guide

PERFORMANCE MEASUREMENT

Who We Are

The **Health Care Transformation Task Force** (Task Force) is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change from volume of services to value of care, both for ourselves and our industry. To achieve this, we commit to have 75 percent of our respective businesses operating under value-based payment arrangements by 2020.

Introduction

Transforming an organization from volume-driven fee-for-service to value can be a complex and challenging experience. The transformation process requires effective leadership, strong strategic planning, sufficient operational resources and dedication at all levels of an organization. Despite the importance of value, very few public resources exist to guide decision-makers in their transformation journey and provide insights from organizations that have successfully transitioned to value.

The Health Care Transformation Task Force (Task Force) has created a *Dimensions of Health Care Transformation Framework* (Framework) to help health care organizations assess their transformational maturity along the value-based payment and care continuum. The structure of the Framework provides the foundation for a series of interviews with provider and payer organizations that are deeply engaged in the transition to value.

These interviews provide insight into the process of transformation: the decisions that organizations must make as they move along the value continuum, the options available to them and their consideration of alternative approaches, the rationale for particular decisions, and the subsequent results of those decisions.



Shared learnings related to changing operational accountability are captured in this report. The report presents this information in a consistent way: (1) common approaches; (2) varying approaches; and (3) lessons learned.

The transformation to value is a long and risky process. There is no clear roadmap to success, and each organization has unique needs and resources. Further, it will not be possible to fully assess the impact of the changes that organizations have made for several years yet to come. Rather than identify industry best practices for delivery system change, the approaches described below illuminate a broader plan for success. In some instances, there is significant alignment about the path forward; in others, the organizations interviewed diverge in their approaches. Together, these findings paint a detailed and diverse picture of the path to transformation to help guide organizations as they embark on their own journey to value.

Dimensions		Concept	Execution	Sustainability
Performance Measurement 	<i>Process and Outcomes Evaluation</i>	What mechanisms are in place to evaluate the implementation, progress, and outcome of value-based care programs? What types of feedback loops are in place to make adjustments based on evaluation results?		
	<i>Financial Modeling</i>	What information does the organization review to perform financial modeling and determine predicted returns on investment? Who is responsible for reviewing financial performance and making refinements?		

Process and Outcomes Evaluation

Common Approaches

Virtually all organizations interviewed have formalized structures for frequent process and performance evaluations. These evaluations typically occur multiple times a year at a minimum, with more formal yearly evaluations. Both payers and providers conduct evaluations that are highly customized to the organization and/or line of business being evaluated.

Continuous improvement and identification/targeting of low performers was a common theme. Several organizations have processes in place to identify and monitor low performers. Payers in particular expressed a strong desire for contracting provider organizations to continuously move toward more risk-based, value-driven contracts:

“Upgrading the relationship over time has been an important part of the process. There’s a clear understanding in the industry that the lower-end models, the attribution-based models in particular, really aren’t the end goal. It’s not the transformative relationship that CMS, progressive employer groups, and others would argue is necessary to try to drive sustainability and fundamental behavior change.”



Letting a provider relationship languish at a lower rung on the transformational ladder is not an acceptable place. Constantly upgrading, motivating, and driving towards a more transformative relationship, and supporting that growth over time, is how we've been successful."

EXECUTIVE; LARGE NATIONAL PAYER

Also common among organizations is the use of standardized reporting tools. For providers, this can take the form of electronic tools that allow multiple levels of drill-down analysis, ranging from the program level to individual providers, and even the individual patient level. These types of reporting tools, which are often synchronized with electronic health record systems, claims data, and admissions, discharges, and transfer (ADT) feeds, allow for more continuous performance monitoring. This type of real-time feedback can be an important motivational tool for providers, especially when results are shared among provider peers.

Developing feedback loops for continuous performance improvement

One large national health system is heavily invested in real-time feedback for its providers. It uses ongoing reporting, as well as peer-to-peer comparisons, to promote a culture of continuous improvement.

"We use regular ongoing report formats for providers that show evidence of their performance versus the benchmark. Regular feedback loops are in place that allow people to see evidence of improvement over time. All that's based on a combination of claims data as well as, in some instances, EMR-based data for some indicators.

It's group-based feedback. We bring together all the chapters for a particular ACO and have a very specific conversation about how they're performing and how the others are performing.

We felt that it was important to do that because there's a certain amount of peer pressure and opportunities to learn from best practices. I would say people have been responsive to that, and we've seen improvement."

Varying Approaches

One of the main differences in how organizations approached process and outcomes evaluation is the use of in-house resources versus consulting or outsourced services. One payer described a process in which consulting teams go onsite with providers to assess their readiness for value implementation and provide a detailed inventory of services and capabilities. Similarly, some providers reported using consulting services to help them develop and implement feedback processes for continuous improvement, while other partner organizations indicated that they offer these services to provider clients.



Approaches to process and outcomes evaluation

<p>Payer</p> 	<ul style="list-style-type: none"> • Use of consulting teams to assess readiness for value implementation and inventory services and capabilities (shared risk arrangements) • Reliance on provider organizations to conduct internal monitoring
<p>Provider</p> 	<ul style="list-style-type: none"> • In-house development of evaluation processes – may build on existing structure and processes • Use of consultants to help design and establish evaluation processes, including use of new technology solutions
<p>Partner</p> 	<ul style="list-style-type: none"> • Partnership with provider organizations to offer expertise, tools, and resources for monitoring – can be short-term (teach-to-independence) or long-term (ongoing technology and resource support)

As previously described, there is variation in how frequently implementation, progress, and outcomes are formally evaluated and monitored. Some organizations offer direct access to tools that allow providers to monitor themselves, but only formally evaluate progress on an annual basis. Furthermore, the types of metrics used to evaluate performance differ by organization.

“For ongoing programs, performance must be measured operationally, medically, and financially. Operational measurement includes leading indicators such as care management productivity (engagement targets), referral patterns, and the use of high-value providers. Medical measurement encompasses cost and use measurement, including traditional metrics of utilization and unit price. Financial measurement should be done for each specific line of business and incorporate factors such as medical loss ratio, per member/per month medical expense, and shared savings.”

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Lessons Learned

Maintaining a manageable scope of evaluation metrics is important, and evaluation processes lose their efficacy when there are too many and/or conflicting measures to track. Furthermore, ensuring that providers are adequately engaged and educated on process evaluation and metrics is crucial for long-term success.

“Our provider community has the opportunity to evaluate their performance across value-based programs on a quarterly basis via a collection of reports and data elements. We encourage providers to continually evaluate progress and share results with leadership/board members to be recognized for successfully delivering upon value-based care or to gather more resources required to demonstrate meaningful improvement moving forward. Additionally, we provide our customers with outcomes and results of our value-based programs to demonstrate how the organization and its provider partners are transforming care delivery.”

EXECUTIVE; REGIONAL PAYER



Engaging providers in meaningful and effective ways is critically important, especially for practices that are not directly employed by a health system and/or who are contracting with multiple different payers. Organizations – both payer and provider – must meet clinicians where they are, rather than forcing adherence to a single transformation path, and evaluate success accordingly.

“We don’t want to have a one-size-fits-all approach, where we just drop in our black box and providers are dependent upon us for their success. At the end of the day, what matters is culture and behavior change.

We’ll get there however we need to. Some of that means providing services and support from our organization. Some of that means helping providers invest in it themselves. Some of that means helping them invest in a third party to provide those services. And we’re comfortable with an all-of-the-above approach.

We’re not narrowly focused on driving revenue into our technology solutions, for instance, or having providers do utilization management in a particular way. We’re trying to get to what works for them, what helps motivate their culture, and drives behavior change within their four walls.”

EXECUTIVE; NATIONAL PAYER

Financial Modeling

Common Approaches

Most of the interviewees use financial modeling to calculate projected expenses and return on investment (ROI). In most cases, ROI is calculated for specific value initiatives and lines of business. Many interviewees acknowledged the difficulty in predicting financial ROI for value-based payment programs. Several cited uncertainties in the legislative and regulatory landscape as impediments to long-term ROI calculations. The majority of payers and providers interviewed remain focused on shorter-term financial modeling, with data analytics, actuarial, and financial expertise used to make predictions. Setting realistic performance expectations was another common theme:

“If we’re incredibly successful, the entire market would move.”

EXECUTIVE; NATIONAL PAYER

“It’s all about incremental improvement... We check with our peers. We look at best practices. We look internally at the data. Where are we off? What do we think our target should be today based on what we know and the resources we have today? What are the new programs or resources we’re going to bring into the organization? Or what’s the reorganization of existing programs and resources?”

We try a program, make it work, spread it, and then make sure we’re getting what we think we should get for it. And if we don’t, we have the rigor to stop.”

EXECUTIVE; NONPROFIT REGIONAL HEALTH SYSTEM

Varying Approaches

Organizations vary in who is responsible for developing financial projections. Some have dedicated departments for financial analysis, while others have different groups responsible for the ROI of various programs. Still others use consultants and partner organizations to analyze and predict financial returns.



One health system indicated that ROI for smaller value programs is usually calculated by the team that proposes the initiative and is based on hypotheses about future state and needs, but that larger value-based investments – such as the Next Generation ACO model – are evaluated by a cross-functional team of financial, clinical, and operational experts. This cross-functional team is then responsible for presenting a business case, including ROI, to the executive leadership team prior to recommendation to the board of directors.

Another payer organization has a specific value unit dedicated to data analytics and financial modeling. This group is responsible for preparing quarterly financial analysis and ROI reports, and works closely with the company’s actuarial team to fine-tune projections. The company credits actuarial rigor for its success in accurately predicting ROI:

“The financial modeling structure has worked well to date – maintaining responsibility for modeling within the value unit has allowed for great flexibility and an ability to adapt modeling to reflect provider and customer inquiries or concerns. We have also been successful largely because of the support of our actuaries and their skill sets/perspective when adjustments are needed to financial models and projections.”

EXECUTIVE; REGIONAL PAYER

Financial Modeling by Organization Type	
<p>Payer</p> 	<ul style="list-style-type: none"> • Dedicated value unit for assessing ROI through data analytics and financial modeling • Teams in charge of various initiatives responsible for calculating ROI, usually with assistance from actuary, data analytics
<p>Provider</p> 	<ul style="list-style-type: none"> • Dedicated value business in charge of assessing ROI and/or working with partner organization to develop and track business case • Teams responsible for smaller initiatives also responsible for ROI; cross-functional team assembled for larger initiatives
<p>Partner</p> 	<ul style="list-style-type: none"> • Responsible for business case that includes financial modeling and ROI using internal finance and actuary resources. Business case is then shared with the health system client and collectively monitored by the partner and the client

Lessons Learned

As discussed above, calculating ROI can be challenging, especially due to uncertainties in the current political environment. Accurate predictions depend not only on sound economic assumptions, but also on the availability of “clean” financial data to help companies assess past performance for predictive modeling. One large provider organization recounted the challenges of predicting its first performance year in value initiatives, and noted that the organization had developed a more rigorous system-wide process for evaluating ROI going forward:



“Year one was a mess. In year two, our data and action process became clearer. This year we are focused on the data we see, past market trends, and other factors. We circle over and over until we are disciplined. The struggle of doing financial ROI is the financial lag. We estimate based on what we’ve done at an episodic payment level, then roll up for hospitals. We talk about trends at meetings, which range from our monthly joint operating committees to weekly and daily huddles. We ask, ‘What is the value proposition at each of those levels?’”

EXECUTIVE; MULTI-STATE PROVIDER SYSTEM

One provider partner also highlighted the critical importance of ensuring that financial goals are tightly aligned with the operational requirements needed to get there:

“Alignment on the financial goals and detailed assumptions is critical for the business case. The system needs to understand the operational requirements that feed into the business case.”

EXECUTIVE; NATIONAL PROVIDER PARTNER

Finally, some executives emphasized that sophisticated technology platforms are not necessary for accurate financial modeling. More important than technology are skilled employees and a rigorous process for financial reporting:

“We did not rely on a large corporate data warehouse to do our modeling. We did it as a stand-alone project. We’ll figure out over time how it fits into other analytic infrastructure. But the cost is not gigantic. It makes sense to do it in a way that’s very focused. It’s relatively straightforward for people who are used to working with claims data. You don’t need to have the most sophisticated IT platform to do this work.”

EXECUTIVE; LARGE NATIONAL HEALTH SYSTEM

Conclusion and Implications

The journey to value is complex, resource-intensive, and highly individualized. What works well in one scenario may not translate well to another. Although there is no “one size fits all” for value transformation, there are many lessons to be drawn from the experiences of organizations that have achieved success in value. The interviews described here, and the Dimensions of Health Care Transformation Framework on which they were based, provide a framework and knowledge base for leaders to draw from as they make strategic value decisions regarding performance measurement.



Recommendations for organizations embarking on the value journey

<p>Provider</p> 	<ul style="list-style-type: none">• Invest in continuous improvement processes. Ensure that you have the appropriate reporting technology, organizational processes, and provider education to identify performance gaps and proactively address them.• Consider sharing performance results among all employed/affiliated physician groups. This may encourage lower performers to improve their scores and incent higher performers to sustain momentum.• Maintain a healthy skepticism of financial ROI projections, especially longer-term projections (> 1 yr). Volatility in the political, regulatory, and financial environments means that long-term projections are usually unreliable.
<p>Payer</p> 	<ul style="list-style-type: none">• Establish a dedicated department/team for value initiatives. Draw support from leadership across the organization, such as actuary and data analytics. Hire experienced staff to build and support reporting capabilities and provider assessments.
<p>Partner</p> 	<ul style="list-style-type: none">• Ensure full alignment with providers on financial modeling. Engage CFO and CTO leaders early in the relationship to make sure there is full engagement and buy-in. Resist making concrete long-term ROI projections.



Detailed Methodology

The Task Force created the Dimensions of Health Care Transformation Framework to assist health care leaders as they design and implement their transition to value. The Framework is built on the collective experience and wisdom from member organizations that are at the vanguard of value-based payment and care delivery. It reflects questions that change leaders should ask themselves in building out a transformation strategy. The Framework was developed from a series of working sessions with the Task Force Path to Transformation Advisory Group, consisting of Task Force members, over a period of several months.

The Task Force used the Framework dimensions to craft an interview guide for members. Task Force staff sought participation from members of the Path to Transformation Advisory Group. Members had the option of participating via phone or through a written response to the interview guide. In total, the Task Force conducted interviews with 12 member organizations, corresponding to over 20 hours of interviews, and received four written responses. The breakdown was as follows:

- 3 payers (two national, one regional)
- 9 providers
- 3 partners (guide providers through value transformation)

Following interview transcription by a professional transcription service, the transcripts and written responses were qualitatively coded using Dedoose, an online coding platform, to highlight and organize key themes among member experiences and observations across each dimension. Task Force staff also completed a summary analysis to enable comparison of approaches and results for similar member organizations. All quotes in this report draw from these interview and written transcripts.

Acknowledgments

This is a product of the Health Care Transformation Task Force under the leadership of the Path to Transformation Advisory Group. The Path to Transformation Advisory Group is comprised of Task Force members who are dedicated to identifying issues and challenges that impact the path to value transformation. The Advisory Group addresses both internal operational challenges of moving toward broad adoption of value and external, atmospheric meta-issues that challenge transformation efforts for health care organizations.