Transformation to Value:
A Leadership Guide

OPERATIONS AND ACCOUNTABILITY

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.

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.

Dimensions		*Concept* *Execution* *Sustainability*
Operations and Accountability 	*Operational Alignment*	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?
	Financial Incentives	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?
	Quality Measurement	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.

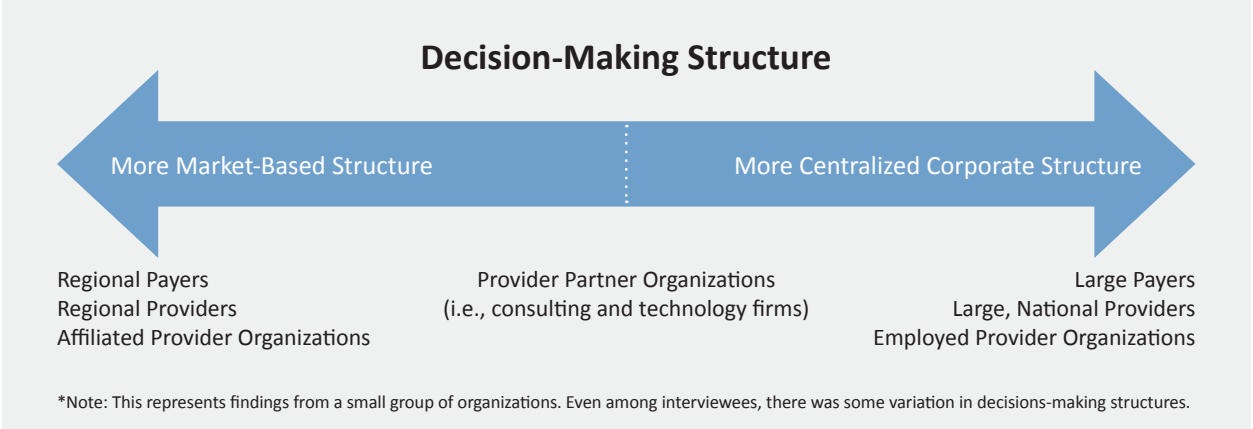
"We do expect people to follow and use standardized approaches and standardized infrastructure, although because we had people starting at different times, and because we've had people join us after they've already started doing some of these things, we end up with people in different states and stages. 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



*Note: This represents findings from a small group of organizations. Even among interviewees, there was some variation in decisions-making structures.

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

Provider 	• 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?
Payer 	• 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.
Partner 	• 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.

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.

Health Care Transformation Task Force Leadership

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Stuart Levine
Chief Medical and Innovation Officer
agilon health

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Peter Leibold
Chief Advocacy Officer
Ascension

Warren Hosseinion, MD
Chief Executive Officer
ApolloMed

David Terry
Founder & CEO
Archway Health

Marci Sindell
Chief Strategy Officer and Senior Vice President of External Affairs
Atrius Health

Dana Gelb Safran, Sc.D.
Chief Performance Measurement & Improvement Officer and
Senior Vice President, Enterprise Analytics Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Kevin Klobucar
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Gary Jacobs
Vice President, Strategic Partnerships
CareCentrix

Carlton Purvis
Director, Care Transformation
Centra Health

Gaurov Dayal, M.D.
Executive Vice President, Chief of Strategy & Growth
ChenMed

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Development Officer
ConcertoHealth

Kevin Sears
Executive Director, Market & Network Services
Cleveland Clinic

Sowmya Viswanathan
Chief Physician Executive Officer
Dartmouth - Hitchcock

Elliot Fisher
Director for Health Policy & Clinical Practice
Dartmouth Institute for Health Policy and Clinical Practice

Shelly Schlenker
Vice President, Public Policy, Advocacy & Government Affairs
Dignity Health

Mark McClellan
Director
Duke Margolis Center for Health Policy

Chris Dawe
Vice President
Evolent Health

Frank Maddux
Executive Vice President for Clinical & Scientific Affairs: Chief Medical Officer
Fresenius Medical Care North America

Angelo Sinopoli, MD
Vice President, Clinical Integration & Chief Medical Officer
Greenville Health System

H. Scott Sarran, MD, MM
Chief Medical Officer, Government Programs
Health Care Service Corporation

David Klementz
Chief Strategy and Development Officer
HealthSouth Corporation

Richard Merkin, MD
President and Chief Executive Officer
Heritage Development Organization

Anne Nolon
President and Chief Executive Officer
HRH Care Community Health

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Martin Hickey, MD
Chief Executive Officer
New Mexico Health Connections

Kevin Schoeplein
President and Chief Executive Officer
OSF HealthCare System

David Lansky
President and Chief Executive Officer
Pacific Business Group on Health

Timothy Ferris
Senior Vice President, Population Health Management
Partners HealthCare

Jay Desai
Founder and CEO
PatientPing

Danielle Lloyd
Vice President, Policy & Advocacy
Premier

Joel Gilbertson
Senior Vice President
Providence St. Joseph

Christopher Garcia
Chief Executive Officer
Remedy Partners

Kerry Kohnen
Senior Vice President, Population Health & Payer Contracting
SCL Health

Richard J. Gilfillan, MD
Chief Executive Officer
Trinity Health

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority