



# 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
<b>Performance Measurement</b>  	<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><b>Payer</b></p> 	<ul style="list-style-type: none"> <li>• Use of consulting teams to assess readiness for value implementation and inventory services and capabilities (shared risk arrangements)</li> <li>• Reliance on provider organizations to conduct internal monitoring</li> </ul>
<p><b>Provider</b></p> 	<ul style="list-style-type: none"> <li>• In-house development of evaluation processes – may build on existing structure and processes</li> <li>• Use of consultants to help design and establish evaluation processes, including use of new technology solutions</li> </ul>
<p><b>Partner</b></p> 	<ul style="list-style-type: none"> <li>• 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)</li> </ul>

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**

<b>Financial Modeling by Organization Type</b>	
<p><b>Payer</b></p> 	<ul style="list-style-type: none"> <li>• Dedicated value unit for assessing ROI through data analytics and financial modeling</li> <li>• Teams in charge of various initiatives responsible for calculating ROI, usually with assistance from actuary, data analytics</li> </ul>
<p><b>Provider</b></p> 	<ul style="list-style-type: none"> <li>• Dedicated value business in charge of assessing ROI and/or working with partner organization to develop and track business case</li> <li>• Teams responsible for smaller initiatives also responsible for ROI; cross-functional team assembled for larger initiatives</li> </ul>
<p><b>Partner</b></p> 	<ul style="list-style-type: none"> <li>• 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</li> </ul>

**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><b>Provider</b></p> 	<ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li><li>• Maintain a healthy skepticism of financial ROI projections, especially longer-term projections (&gt; 1 yr). Volatility in the political, regulatory, and financial environments means that long-term projections are usually unreliable.</li></ul>
<p><b>Payer</b></p> 	<ul style="list-style-type: none"><li>• 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.</li></ul>
<p><b>Partner</b></p> 	<ul style="list-style-type: none"><li>• 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.</li></ul>





## 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.



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