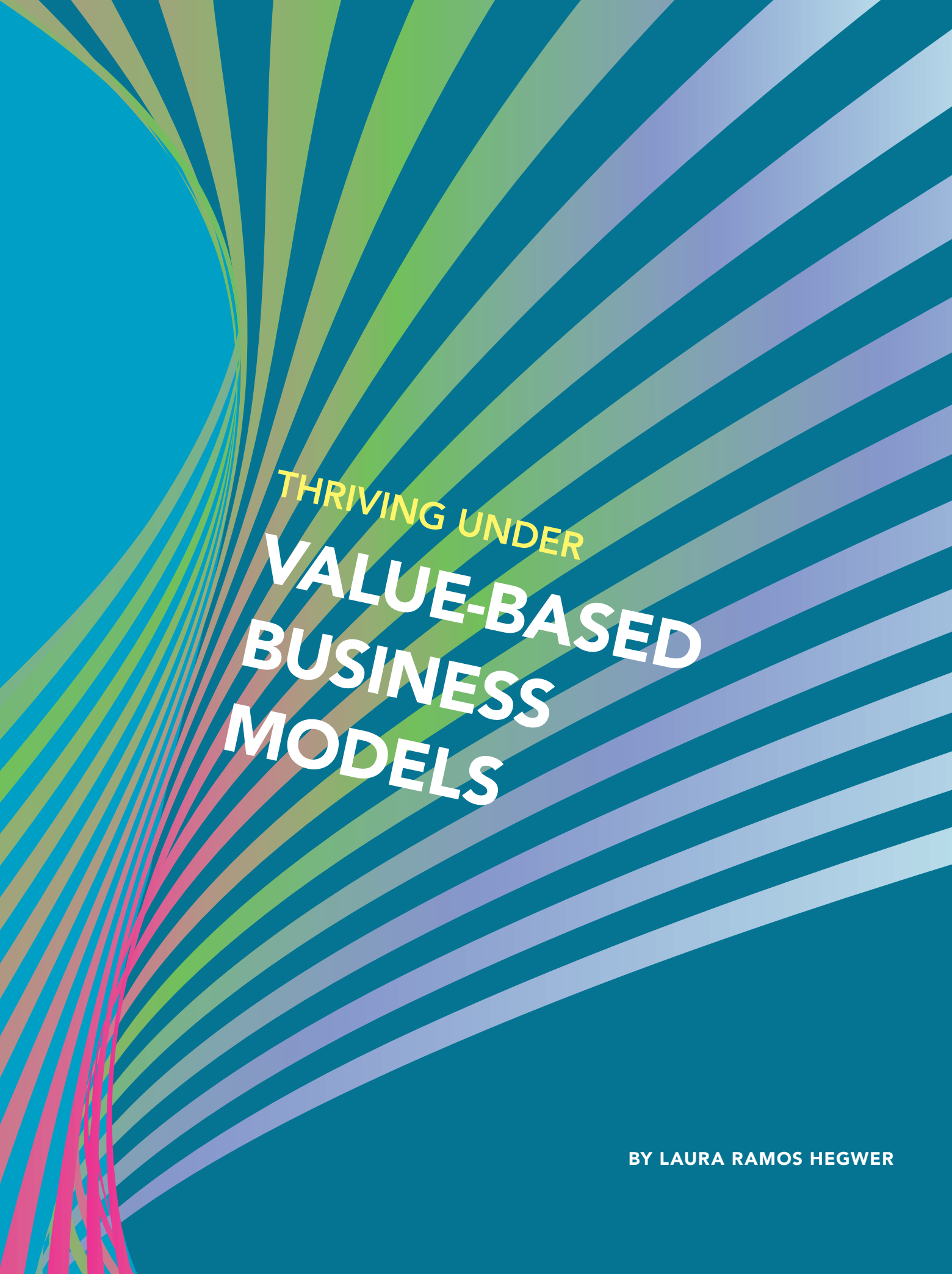
THRIVING UNDER
VALUE-BASED
BUSINESS
MODELS
BY LAURA RAMOS HEGWER

LEADING HOSPITALS AND HEALTH SYSTEMS ARE BUILDING NEW CAPABILITIES AS THEY POSITION THEIR ORGANIZATIONS FOR VALUE.

Healthcare executives across the country recognize that value-based payment is on the rise, but many are wary of making a misstep as they prepare to shift their business models away from fee for service.

In fact, many experienced leaders recall the capitated arrangements of the 1990s that burned providers who did not understand how to manage risk. "No one enters into a risk-based contract thinking that it won't produce good results," says Andrew S. Cohen, senior vice president, Kaufman, Hall & Associates, LLC, Skokie, Ill. "But that's the reality for many of these programs, at least in the early stages."

To succeed under the latest value-based payment models, hospital executives need to do more than minimize their cost per episode. "They need to make some significant investments upfront to build their foundational skills and capabilities," Cohen says. "Specifically, they need to develop competencies for both population health management and service-level consumerism driven by patients who will have different tools and incentives than they do today to purchase and consume healthcare."

Following are examples of organizations that shared their progress toward developing such competencies at an ACHE Fund for Innovation in Healthcare Leadership program.

CREATING LOYALTY

Providers can prepare for success under value-based payment models by engendering patient loyalty, or what marketing executives refer to as "stickiness," Cohen says. Promoting quality care, using IT wisely and ensuring a superior patient experience all can help providers cultivate loyal consumers. This will be critical for providers with accountable care organizations, which in some instances do not require patients to receive their care within a specific provider system. "Now, hospitals and physicians have to think differently about how they can keep patients within their network of providers so they can manage the care and cost of care effectively," Cohen says.

Sutter Medical Center, Sacramento, Calif. Putting the patient front and center is one of the best strategies healthcare leaders can have as they transition to value-based payment models, says Richard Soohoo, CFO of Sutter Medical Center.

"Hopefully, we entered healthcare for the right reasons, which is to provide the best possible care to the patients we are privileged to serve," Soohoo says. "We need to continue that as our main focal point as we move through these creative and dynamic times. If we are able to keep patients at the center of everything we do, we are going to end up in the right place."

Case in point: Sutter Medical Center plans to expand its patient portal, My Health Online, to help meet the expectations of younger patients who want quicker access and more responsive communication with their providers.

"Today, patients expect to be able to communicate electronically with their physicians," Soohoo says. "If we are going to succeed, providers will need to adapt their traditional ways of business moving forward."

Robert C. Sehring, CEO, Central Region, OSF HealthCare, Peoria, Ill., believes educating employees on the increasing importance of quality metrics and patient satisfaction is essential to success.

Leaders at Sutter Medical Center also are stepping up their efforts to manage patients with late-stage chronic illnesses through Sutter Health's Advanced Illness Management® program, which received a three-year, $13 million grant from the Center for Medicare & Medicaid Innovation. The program is designed to create a coordinated system of care beyond the hospital, led by a virtual care team that includes physicians, nurses and social workers. To date, the program has enrolled nearly 10,000 patients. So far, the results have been impressive: Savings to payers exceed $9,400 per patient, thanks in large part to a reduction in hospitalizations, ICU days and emergency department usage. Overall patient and family satisfaction with the program is 94 percent.

Still, challenges remain for Sutter Medical Center, which has been conducting business in a hybrid value-volume model since the early 1990s. Unlike other areas of the country, California never abandoned capitated, full-risk arrangements. In addition, the state's Corporate Practice of Medicine doctrine prevents hospitals from employing physicians, which can make aligning incentives difficult. "When your hospital is

held to a value-based methodology and your physicians for the most part are not, it is challenging for all of us," Soohoo says.

HARNESSING ANALYTICS

Leading healthcare organizations recognize that successfully managing populations requires sophisticated analytics tools. "Data and IT will be the backbone of population health management programs," Cohen says.

Lehigh Valley Health Network, Allentown, Pa. Since 1988, LVHN has owned a third-party administrator, which manages the organization's employee health and dental plans and has managed plans for employers in six states. LVHN, which includes five hospital campuses and 12 health centers, also launched its own physician-hospital organization in 1993. Shortly after the Affordable Care Act became reality in 2010, LVHN created a healthcare analytics services company to develop population health management tools and capabilities.

"We wanted to leverage some of the competencies that we developed within our TPA to begin thinking and acting more like an insurer, namely how they manage populations," says Gregory G. Kile, senior vice president, insurance and payer strategies at LVHN and an ACHE Member. "Instead of relying on actionable information from payers, we chose to build our capabilities internally and use our own language so we weren't doing one-offs with various payers. This allows us to negotiate standardization of performance metrics for all of our payer arrangements, and we provide those metrics directly to providers after we marry claims data from carriers with the clinical data in our EMRs." LVHN has built upon a third-party platform of clinical informatics tools to analyze member and provider data and business intelligence software to help providers visualize the data.

In addition, LVHN formed a population health management executive work group comprising medical directors and other clinical leaders to help prioritize clinical initiatives based on insights they gain from the data. For example, the work group is using analytics tools to review cost and utilization data so they can design more effective clinical pathways for stage 1 breast cancer, atrial fibrillation and hip and knee replacements.

Within its employee population, LVHN has cut nearly $6 million from its medical expense budget and bent the cost trend by 6 percent. The network currently manages 104,000 lives, which is anticipated to rise to 176,000 by the end of 2016. LVHN also has a Medicare Shared Savings Program ACO that went live in January 2015.

"Value-based contracting is only 3 percent of our current revenue, but payers in our market are accelerating rapidly toward shared savings and shared risk," Kile says.

REVAMPING CARE MANAGEMENT

As healthcare organizations prepare to take on more accountability for outcomes in ambulatory settings through bundles and other risk-based payment models, they need to improve their communication and coordination across the continuum of care, Cohen says. "Providers need to think more broadly about whom they are going to work with in a care team to manage the patient over a longer period of time and across a broader range of services than what they may have been accustomed to," he says.

OSF HealthCare, Peoria, Ill. During the past year, OSF HealthCare, an integrated health system with 11 acute care facilities and 18,000 employees, reorganized its care management division to better reflect how patients move through the care continuum. Specifically, leaders moved all of the organization's inpatient utilization review nurses, case managers, social workers, discharge planners and complex care managers from their outpatient settings under one

organizational umbrella. Job descriptions also were rewritten to include more of a population health focus.

"As we manage larger population health arrangements, we have to make it a very smooth continuum for patients," says Ralph R. Velazquez, MD, senior vice president, care management, at OSF HealthCare. "To do that, we have to speak a common language and develop common processes." Leaders at, OSF HealthCare also moved their various care management tools to a single platform, which allows the care team to trace the patient's progress along the continuum.

Back in 2011, healthcare leaders at OSF HealthCare saw the Pioneer ACO model as "an opportunity to speed the transformation of how healthcare was financed," says Robert C. Sehring, CEO, Central Region. OSF HealthCare's quality metrics improved year after year in the Pioneer ACO program. Yet in the first two years, the savings generated were not enough for OSF HealthCare to earn a bonus. That changed in 2014, when OSF HealthCare received a bonus just under $5 million.

Early on, leaders at OSF HealthCare made the decision to extend their increased care management to all patients, not just their Pioneer ACO patients. As a result, they have seen overall improvements in areas such as readmissions and hospital-acquired infections.

OSF HealthCare also has entered into several risk-based arrangements with Medicare Advantage plans and commercial plans. The organization only has a few direct contracts with employers; most include a pay-for-performance component, rather than true risk-sharing. "Today in our markets, payers and large

Beyond Size and Segment, Various Other Factors Will Influence Employer Plan Decisions in Local Markets

Driver	Commentary	Varies by Market?
Wage Levels	Lower-wage firms are more likely to shift to public exchanges due to subsidy availability and lower foregone tax shield.	☑
Industry	The importance of health benefits for recruitment and retention will be higher for more skilled labor.	☑
Geographic Distribution of Employees	More practical to consider direct contracting when employees are concentrated.	☑
Part-Time vs. Full-Time Workforce	Companies with large part-time workforces are among the first to shift to public and private exchanges.	☑
General Fast-Follower Preference	Employers generally prefer that others test new models and then adopt quickly once they are proven.	☑
Paternalism	Many employers have a paternalistic mindset that leads them to maintain more direct control over benefit decisions.	☑
Cadillac Tax	Avoiding the 2018 excise tax on high-cost plans will increasingly drive more aggressive plan designs.	☑

"Providers need to recognize the drivers in their market and what stakeholders are doing so they can predict the velocity of how quickly the market is moving away from fee-for-service to value-based care delivery," says Andrew S. Cohen of Kaufman, Hall & Associates, LLC. This includes understanding the factors that will influence employer plan decisions in local markets.

Source: Kaufman, Hall & Associates, LLC

health systems like ours, rather than employers, are driving the transition to value-based arrangements," Sehring says.

He believes educating employees on the increasing importance of quality metrics and patient satisfaction is essential as healthcare organizations make the transition to value. "We underestimated the amount of communication and change management that were required to transform a large organization like ours," Sehring says. "Part of the challenge is that we still have more than 70 percent of our revenue and 60 percent of our patient population in fee for service. It is difficult to tell people that things are changing when their day-to-day work is still in the fee-for-service world."

7 STRATEGIES FOR SUCCESS UNDER VALUE-BASED BUSINESS MODELS

Healthcare leaders should consider the following lessons learned from executives who understand what it takes to thrive under the payment models of the future.

Understand how fast your market is changing. "Providers need to recognize the drivers in their market and what stakeholders are doing so they can predict how quickly the market is moving away from fee-for-service to value-based care delivery," Cohen says. This includes understanding the factors that will influence employer plan decisions in local markets.

Form intelligent partnerships based on your population. For example, the kind of partners you need for a managed Medicaid contract will likely be different from the partners you need for a commercial employer contract," Cohen says. Sutter Medical Center, for example, is part of an urban market that does not include a county health system. To serve the area's large Medi-Cal and uninsured population, Sutter Medical Center established a strong strategic partnership with a federally qualified health clinic. Nurse navigators from the FQHC are based in Sutter Medical

ABOUT THE FUND FOR INNOVATION IN HEALTHCARE LEADERSHIP

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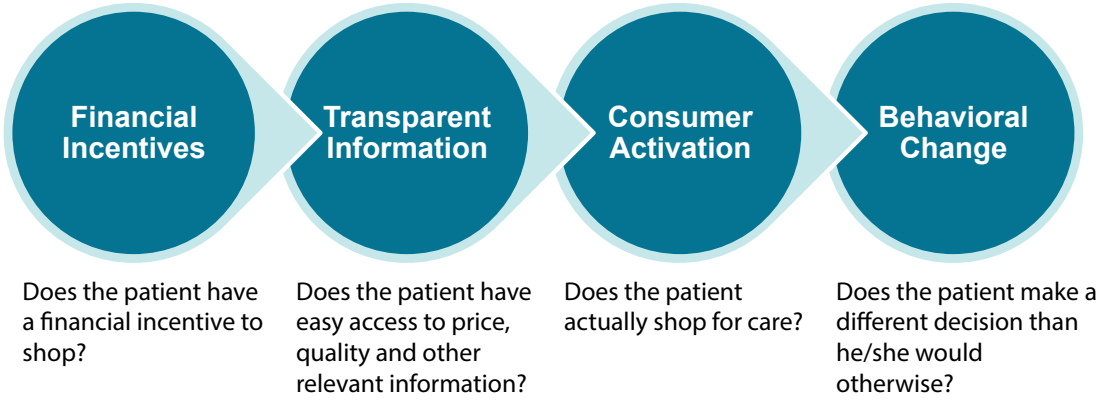
The Fund was established in 2006 to bring innovation to the forefront of healthcare leadership by developing and enhancing its focus on future healthcare leaders, ethics in healthcare management and healthcare management innovations. In its commitment to developing future leaders, the Fund also has provided scholarships for the Foundation of ACHE's Senior Executive and Executive Programs.

Since the Fund's inception, more than 2,400 generous donors have made contributions totaling more than $3.1 million. This support has enabled the Fund to strengthen the field of healthcare leadership by providing educational opportunities on important trends and issues.

For more information on the Fund, including ways to contribute, please visit ache.org/Innovation or contact Timothy R. Tlusty, vice president, Development, ACHE, at (312) 424-9305 or ttlusty@ache.org.

Multiple Factors Must Intersect for Service-Level Consumerism to Drive Meaningful Market Shifts



Several factors will need to intersect for consumerism to drive meaningful market shifts.

Source: Kaufman, Hall & Associates, LLC

Center's ED and help redirect nonacute patients to more appropriate levels of care.

Develop payer competencies. LVHN recruited insurance industry executives to help position the organization for population health management. "You need colleagues who understand what it means when we talk about cost from a health insurer's perspective and how it differs from a health system's perspective," Kile says.

Join a consortium. As part of the Health Care Transformation Task Force, a private-sector alliance that seeks to accelerate the move toward value-based payment, OSF HealthCare has joined like-minded providers, payers and purchasing organizations that are committed to moving 75 percent of their business into value-based arrangements by 2020. "The task force provides an opportunity for us to come together and share best practices on what seems to be working and what kind of infrastructure is needed to be successful at managing populations," says OSF HealthCare's Velazquez.

Address behavioral health and social issues. OSF HealthCare has embedded behavioralists and therapists in its primary care clinics in several markets. The health system wants to build bridges with community service organizations that can help address social issues such as poverty and food insecurity. It also is leveraging technology. "In some of our rural markets, telehealth may be the best option to get behavioral health into the community," Velazquez says.

Focus on patient satisfaction as well as employee satisfaction. OSF HealthCare has designated employee champions who are responsible for patient satisfaction in different settings. They also are striving to improve employee satisfaction. "We don't believe we can meet the high standards that we set in the patient experience if we don't have an engaged workforce," Sehring says. "They really go hand in hand."

Engage physician leaders. "Physicians are the front line in these new models," Cohen says. "Organizations need strong physician leadership to determine how they are going to coordinate care and maintain relationships with their patients. Without that connectivity across the organization and network, there is a strong likelihood that these programs will not be successful."

Laura Ramos Hegwer is a freelance writer and editor based in Lake Bluff, Ill.