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81%
of respondents say they have developed telehealth competencies in preparation for value-based care

INTELLIGENCE REPORT

JANUARY/FEBRUARY 2021

VALUE-BASED CARE ADVANCES, BUT TRANSITION PROVES CHALLENGING

PERSPECTIVE 2

ANALYSIS AND RESULTS . . . 3

METHODOLOGY 13

RESPONDENT PROFILE . . . 14

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SOUND PHYSICIANS™

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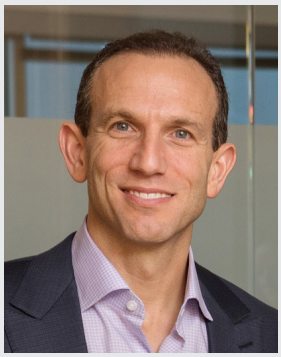
MANDATORY BUNDLES ARE COMING: HOW PHYSICIANS CAN HELP YOU MANAGE ACUTE EPISODES OF CARE

As providers continue their efforts to manage the total cost of care under value-based payment models, strategies must expand from traditional primary care–based levers that keep patients out of the hospital. Many organizations overlook that 50% of Medicare spending occurs within acute care episodes—from hospitalization through 90 days post-discharge. However, CMS has not missed this. After 10 years of demonstration, CMS recently announced their intent to make episodic ("bundled") payments a mandatory program in 2023. The considerable unexplained variation in episode utilization, particularly during the post-acute period, offers value-oriented providers significant opportunities to continue their transition from volume to value.



Robert Bessler, MD
CEO and Founder
Sound Physicians

Cultivating physician ownership of total cost of care

Overutilization and *excess costs* are terms that resonate with large employers and health plans, but not generally with clinicians—whose hearts and minds focus on quality care for their patients. Provider organizations must consistently frame the total-cost-of-care challenge regarding improvements in patient experience and outcomes that clinicians can see and feel. At Sound Physicians, we show clinicians how practice changes are linked to outcomes research and utilize data and analytics to illustrate these relationships within our own practice. For example, when our hospitalists engage patients and their families in advance care planning conversations, they understand how aligning care with patients' wishes leads to improved patient experience, appropriate clinical treatment, and a reduction in futile care and adverse outcomes. We further reinforce this linkage with a physician compensation strategy that aligns to these practice goals.

Moving from reactive to proactive technology enablement

Data and analytics technology has been successful in helping clinicians retrospectively understand compliance with desired protocols. However, the next enablement leap for value-based practice is to use dynamic clinical workflows to structure and inform care planning and point-of-care decision-making. The right tools enable hospitalists to build care plans upon admission and improve quality by referencing data relevant to targeted decision points while rounding. At Sound, we've developed SoundConnect™, our physician-designed rounding tool, to do just this, and SoundMetrix™, which provides a risk-adjusted evaluation of clinical decisions and outcomes. By embedding these proactive technologies into daily practice workflows, we have improved adoption of value-based care behaviors and clinician satisfaction.

It's worth the journey

Sound Physicians began its value-based journey six years ago, with CMS' Bundled Payment for Care Improvement initiative. We believed our hospital partners would prioritize value-based care and that we could provide meaningful support. We knew it would take time and resources to build the capabilities, and while the first two years in the program proved challenging, we eventually beat national episode spending trends by 50%.

Our national performance in BPCI:

- 15% reduction in 30-day readmission rate
- 26% reduction in utilization of SNF
- 12x increase in advance care planning use rates
- $1,000 savings per episode
- Episode costs decreased 50% faster than national trends

Organizations looking to develop or improve their approach to value-based care should consider the costs tied up in acute episodes of care and seek physician buy-in to their strategy. When aligned, hospital-based physicians are educated and supported to deliver the right value-based interventions, and the quadruple aim is well within reach.

VALUE-BASED CARE GAINS FOOTHOLD, BUT STILL HAS A WAYS TO GO

The coronavirus pandemic is providing value-based healthcare with an opportunity to prove its worth. Can it deliver?

It's too early for a definitive answer, but the early reviews suggest it may have more staying power as the public health emergency exposes weaknesses in other payment options.

John Commins
Senior Editor
HealthLeaders

"It certainly showed that fee-for-service as a financing model has a lot of fragility to it," says Jaewon Ryu, MD, JD, President and CEO of Geisinger, a Danville, Pennsylvania, health system that has been on the vanguard of the value-based movement.

"When you're in a prepaid, value-based environment, you could really focus on just figuring out how to get the care to the patient, regardless of setting, regardless of whether it's billable or not, just to try to keep them healthy in the most creative ways possible, and we were able to do that," he says.

Ryu says the basic tenets of value-based care—proactive care coordination to keep people out of the hospital—"were very handy during the pandemic."

"Those same people do very similar things during a pandemic when they have to reach out or return results on COVID tests, making sure patients have adequate resources and monitoring at home so that they can map the progress and make sure that they don't need to come into the hospital," he says.

Is the pandemic success of value-based care enough to push the payment model across the threshold?

"I don't know but I hope it does," Ryu says. "Old habits die hard, and to the extent that people and systems are spring-loaded to deliver fee-for-service results, it's still going to require more to get transformation in the delivery system."

A slow transition

A new HealthLeaders value-based care survey of healthcare executives attempts to determine the readiness of value-based care, and the overall findings suggest that two-thirds of respondents are gaining comfort with value-based, while one-third are not.

Kevin J. Conroy, MS, Chief Financial Officer and Chief Population Health Officer at CareMount Medical in Chappaqua, New York, says that shouldn't be surprising because value-based care "is not easy."

ANALYSIS AND SURVEY RESULTS

Figure 1 | **Considering the industry's direction toward value-based care, what is your organization's level of strength in each of the following?**

	Very strong	Somewhat strong	Somewhat weak	Very weak
Overall preparation for value-based care delivery changes	25%	45%	28%	3%
Overall preparation for value-based financial changes	23%	52%	21%	4%
Overall preparation of a value-based infrastructure	20%	50%	29%	2%

Base = 105, ranked by responses for very strong

"There's a tremendous amount of investment, in terms of capital, infrastructure, personnel, and culture within an organization, in order to be successful," he says. "There are medical groups who, for a variety of reasons, may not be in a position to invest in what it takes to do this."

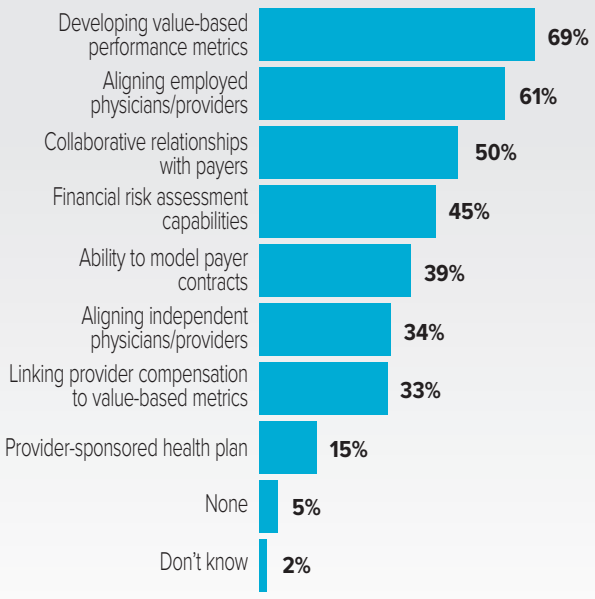
Conroy says some providers may be in regions or comprised of medical specialties that continue to be dominated by a fee-for-service market. "But at the end of the day, value-based care is definitely moving forward, and all group practices and all executives that run practices need to be ready," he says.

Value-based care capabilities

When asked about their organizations' financial, care delivery, and infrastructure strengths in the transition to value-based care, two-thirds of respondents rated their efforts as "very strong" or "somewhat strong," in slightly varying amounts, while one-third rated them as "somewhat weak" or "very weak" (Figure 1).

"I would have expected a lot more people would say, 'We're ready on the financial side, but we're not as ready on the delivery system side or the value-based infrastructure side,' but I was a little surprised that by and large the ratings were similar," Ryu says.

Figure 2 | **In which of the following areas of healthcare finance has your organization developed competencies to prepare for value-based care?**



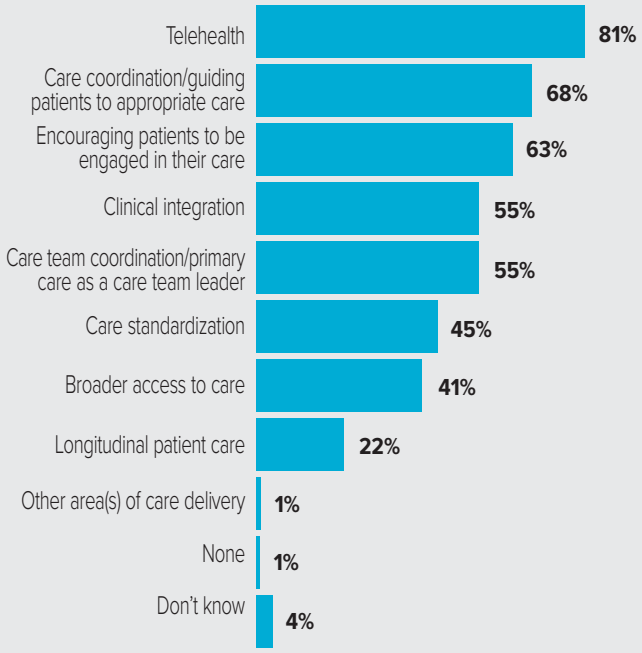
Base = 105, Multi-response

Figure 3 | **Please rate the following areas of healthcare finance according to your organization's ability to deliver value-based care.**

	Very strong	Somewhat strong	Somewhat weak	Very weak
Developing value-based performance metrics	35%	47%	16%	2%
Aligning employed physicians/providers	32%	45%	14%	9%
Financial risk assessment capabilities	26%	45%	24%	5%
Ability to model payer contracts	17%	46%	35%	2%
Collaborative relationships with payers	16%	50%	30%	4%
Aligning independent physicians/providers	15%	46%	26%	13%
Other area(s) of finance	13%	47%	30%	10%
Linking provider compensation to value-based metrics	10%	48%	31%	11%
Provider-sponsored health plan	10%	34%	37%	19%

Ranked by responses for very strong. Base = 98, of those who have developed these competencies.

Figure 4 | **In which of the following areas of care delivery has your organization developed competencies to prepare for value-based care?**



Base = 105, Multi-response

The responses also suggest that the road to value-based care is harder than many providers anticipated.

"A lot of folks think that once you have the financial incentives you're off and running. You just hire a few care coordinators and off you go," Ryu says. "Our experience has been that that's not sufficient. The financial incentives create the right environment, and having the right environment is only the first step. After that, you need to look at workflows and how is your delivery system modeled. That takes time, and it's essentially a build job."

Ryu offers a couple of examples of value-based programs that Geisinger has built, including a home-based care model for the sickest 3% of its patient population.

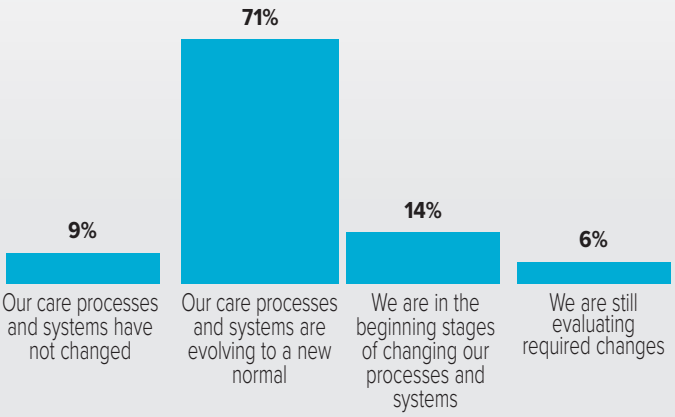
"That's a program that was a meaningful investment and took quite a bit of time to build properly and we still

Figure 5 | **Please rate the following areas of care delivery according to your organization's ability to deliver value-based care.**

	Very strong	Somewhat strong	Somewhat weak	Very weak
Encouraging patients to be engaged in their care	30%	46%	23%	1%
Care coordination/guiding patients to appropriate care	29%	55%	15%	1%
Telehealth	25%	60%	15%	0%
Clinical integration	23%	51%	24%	2%
Broader access to care	20%	54%	23%	3%
Care team coordination/primary care as a care team leader	19%	49%	29%	3%
Care standardization	17%	48%	27%	8%
Longitudinal patient care	9%	40%	45%	6%
Other area(s) of care delivery	6%	55%	30%	9%

Ranked by responses for very strong. Base = 100, of those who have developed these competencies.

Figure 6 | **As a result of the pandemic, how have you changed your processes and systems for supporting your care teams and practices in their coordination, communication, and patient outreach efforts?**



Base = 105

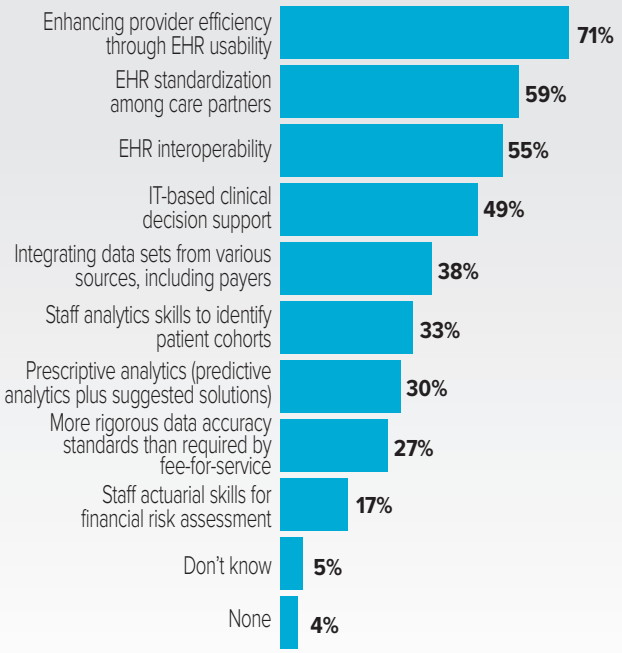
fine-tune," Ryu says. "We've also seen utilization rates dropped by 30% to 35% and hospital admission rates dropped by 25% in that population."

In 2017, Geisinger began a primary care redesign in the transition from fee-for-service to value-based care that took about 18 months to work its way through all primary care providers in the health system.

"We also slowed down our providers and, today, on average, every primary care physician and advanced practitioner in our system sees a couple of patients less per day than they did back in 2017," Ryu says. "Those are the kind of moves that you really need to build out as far as infrastructure with data and care coordinators."

"At the same time, you need to rejigger your care delivery model so that it gears towards keeping people safe, out of the hospital, healthy, out of the ERs, those kinds of things."

Figure 7 | **For which of the following IT items has your organization developed competencies to prepare for value-based care?**



Base = 105, Multi-response

Telehealth as "the enabler"

When it comes to developing competencies to prepare for value-based care, an overwhelming number of respondents (81%) said telehealth was their top priority (Figure 4).

That was no surprise to either Ryu or Conroy, who see telehealth competency as a foundational block for value-based care.

"Given the costs of patient care, telehealth is an important option to have, especially in rural areas where access to providers is perhaps more difficult and in more urban areas where it's difficult to get an appointment," Conroy says.

He adds that Medicare's move to reimbursement parity for telehealth during the coronavirus pandemic was a key driver that "incentivized physicians to actually make the time to participate in telehealth as a means of providing care."

"Having the opportunity to stay in touch with a patient, particularly those with multiple chronic conditions, is critical," he says, adding, "I believe that to be true regardless of whether an organization is under a value paradigm or a fee-for-service paradigm."

Ryu says the pandemic has demonstrated the importance of telehealth.

"We've seen COVID serve as a catalyst really for all telehealth," he says. "The comfort level of people launching telehealth programs and the comfort levels of consumers and patients has inspired a lot of confidence, and so that 81% is absolutely real and this is one of the strange silver linings of COVID."

Ryu says providers rightly see telehealth as "an enabler" for other value-based competencies such as care coordination, clinical integration, patient engagement, and access.

"That's the right way to look at it. It's really everything else that's further down the line," he says.

"Think of it as another mode of communication that allows either providers or care teams to connect with patients or care teams to connect with one another," he

Figure 8 | **What is your organization's level of strength in each of the following IT items, specifically in relation to the change from fee-for-service to value-based care?**

	Very strong	Somewhat strong	Somewhat weak	Very weak
Enhancing provider efficiency through EHR usability	23%	58%	16%	3%
EHR standardization among care partners	21%	53%	21%	5%
EHR interoperability	15%	57%	24%	4%
Staff analytics skills to identify patient cohorts	14%	45%	38%	4%
Integrating data sets from various sources, including payers	14%	41%	38%	8%
IT-based clinical decision support	13%	47%	33%	7%
More rigorous data accuracy standards than required by fee-for-service	10%	46%	35%	8%
Staff actuarial skills for financial risk assessment	10%	33%	42%	15%
Prescriptive analytics (predictive analytics plus suggested solutions)	7%	45%	34%	14%
Other infrastructure element(s)	4%	43%	36%	17%

Ranked by responses for very strong. Base = 96, of those who have developed these competencies.

says. "When you enhance communication in that way, we've seen good things happen."

Evolving to a new normal

When asked how the pandemic has changed value-based care processes for care coordination, patient outreach, and communication, 71% of respondents said they were "evolving to a new normal" (Figure 6).

"That resonates with us as well. That's probably where we are, and that's where most health systems are," Ryu says. "Telemedicine was one example, but there are many others, even how you have flow through the clinics, setting up surge capacity areas, reaching out to the community. These are all areas that we've been very quick to adopt."

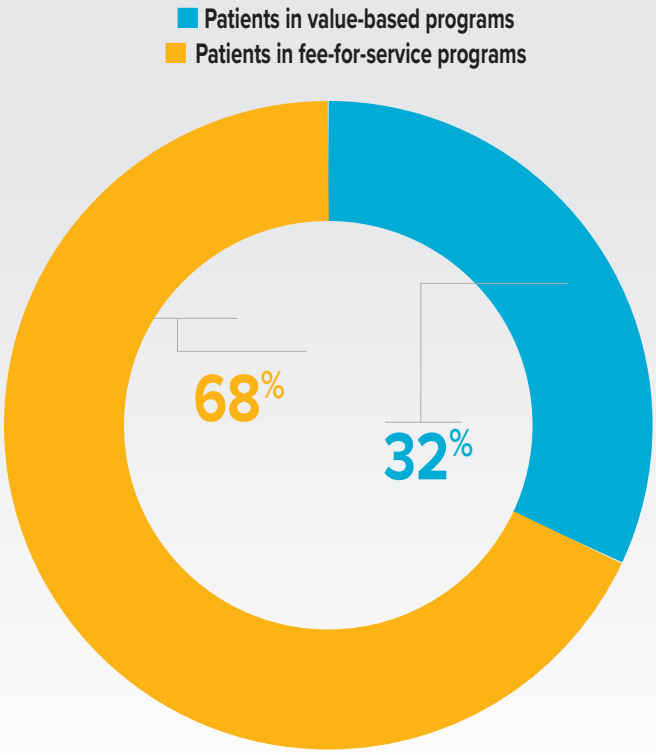
Ryu says the pandemic has also created an opportunity for health systems "to embrace their mission as public health stewards."

"Not all health systems really view themselves as having a role within public health, but many do," he says. "As a result of the pandemic, it's accelerated investment and dedication to those kinds of capabilities."

Conroy says CareMount is also evolving to the new normal necessitated by the pandemic.

"Taking a more proactive position on patient outreach is probably the new normal for us, but we were evolving toward that anyway," he says. "Patient communications was on our radar before COVID, and we had invested

Figure 9 | What share of your organization's patients are in your value-based vs. fee-for-service programs currently?



Base = 105

heavily to improve our patient portal and other means of staying in touch. Once COVID hit, we doubled down to be able to keep in touch with our patients, particularly those who were most vulnerable, to make sure they were taken care of."

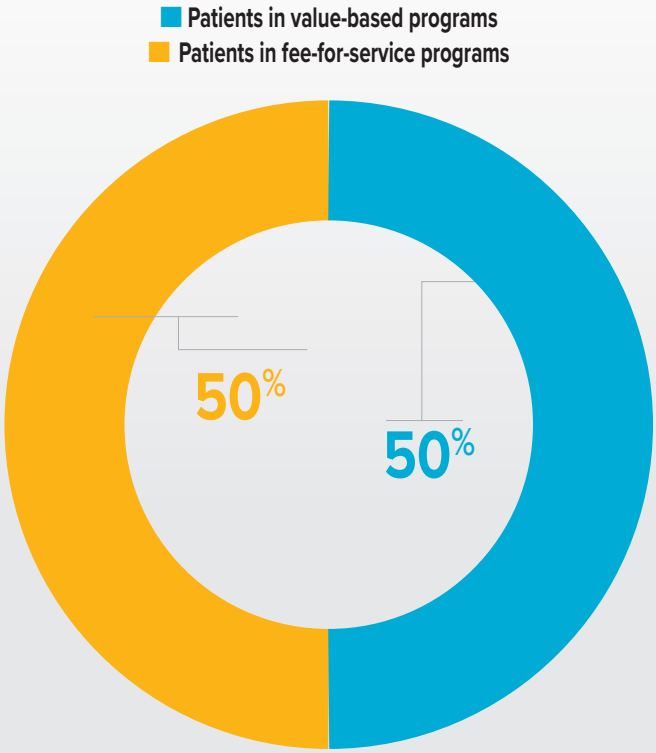
Because the pandemic was "unknown territory," Conroy says, they also invested heavily in communicating internally. "We were having twice-weekly meetings with various levels of physicians and with employees in addition to our patient outreach," he says.

Enabling EHR usability

Enhancing provider efficiencies through EHR capabilities was also the top focus (71%) of respondents (Figure 7).

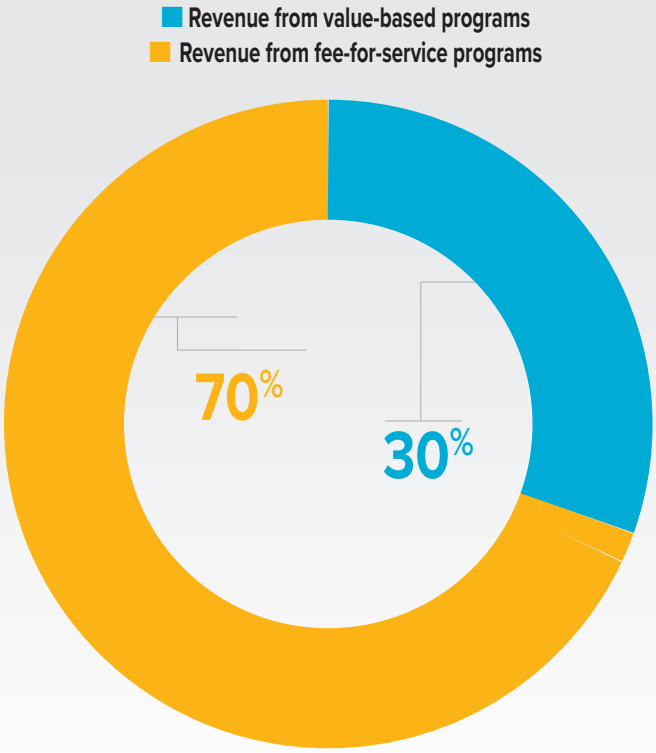
"That again resonates with our experiences," Ryu says. "The key to any kind of transformation and delivering better value within the delivery system is all about trying to make the path of least resistance the same path that keeps people healthy and out of the ERs and out of the hospitals."

Figure 10 | What share of your organization's patients will be in your value-based vs. fee-for-service programs in three years?



Base = 105

Figure 11 | **What share of net patient revenue do value-based and fee-for-service payment models represent in your organization's most recent reconciled fiscal year?**



Base = 105

Ryu says Geisinger has had success embedding decision support and facilitating information access for physicians when they're ordering or contemplating what the care plan needs to be.

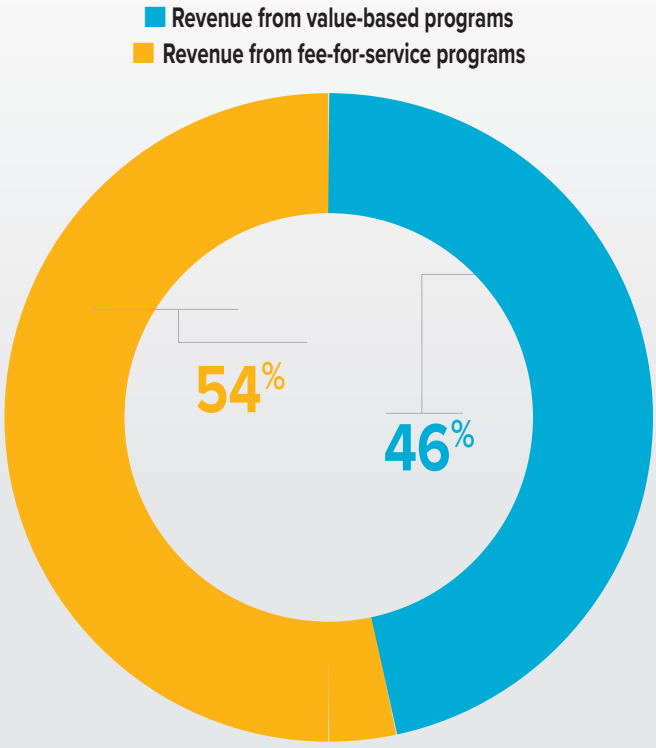
"That information is invaluable," he says.

Conroy says interoperability has been CareMount's focus over the past several years.

"If you don't have an EHR that offers interoperability—meaning the technology is highly interactive and can electronically share health-related data between several organizations—you're simply not going to be successful," he said. "Outside of our EHR, we use physician report cards so physicians understand how they're doing on wellness visits, or how they're doing on various quality metrics. We also align those physician metrics to compensation and incentive programs. We are relying on more software enablement tools that evolved from our value-based programs."

Conroy warns all the efforts to gin up IT capabilities for value-based care could be for naught if the data

Figure 12 | **What share of net patient revenue will value-based and fee-for-service payment models represent in your organization in three years?**



Base = 105

Figure 13 | **Overall, what has your organization's experience been with the following payment models?**

	Improved outcomes and reduced costs	Improved outcomes, no cost reduction	Neither improved outcomes nor reduced costs	Don't know results of our experience with this program	No involvement with this program	Don't know if we have experience with this program
Fee-for-service with upside rewards, such as performance awards	29%	37%	16%	9%	9%	1%
Shared risk, such as ACO	25%	21%	14%	8%	24%	9%
Medicare Shared Savings Program with upside rewards only	24%	30%	17%	10%	15%	4%
Bundled payment program(s)	24%	18%	20%	8%	23%	8%
Medicare Shared Savings Program with upside and downside	20%	16%	26%	10%	24%	4%
Fee-for-service with downside risk, such as reimbursement penalties	15%	15%	27%	12%	24%	7%
Fee-for-service with no value-based component	13%	33%	40%	9%	4%	1%
Partial capitation	12%	17%	22%	14%	28%	7%
Full capitation	10%	12%	14%	15%	31%	16%

Base = 105, ranked by responses for improved outcomes and reduced costs.

generated by your EHR is weak or inaccurate. "To me, data accuracy is paramount to build trust," he says. "You can have the greatest systems, but if you're not pumping out accurate information, or if you're not measuring in an appropriate or accurate way, physicians are going to lose confidence in your system."

"Now comes the heavy lifting"

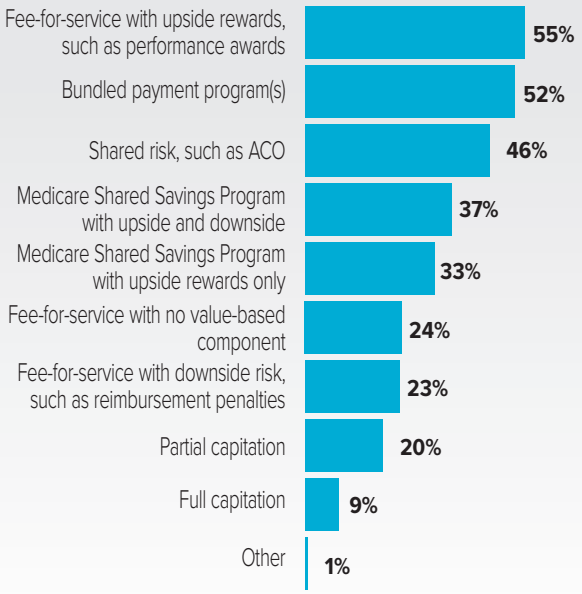
Conroy says the survey results tell him that "there's a mindfulness toward value-based care and its importance and its place in the healthcare paradigm, but actual participation in these programs is still lagging. We have to prioritize value-based care."

Providers may need a bigger push, Conroy says, and that will likely have to come both internally and from payers.

"The government, through Medicare, is trying to promote more participation by reimbursing based on value-based care metrics and measures. As that progresses, I suspect the commercial payers will begin to follow. That's one driver," he says. "The second driver is the continuing increase in healthcare costs. Employer groups and pressures on the healthcare economic system as a whole are also going to drive the move toward value-based care."

"Now comes the heavy lifting," Conroy says, starting with significant investments. "The investments have to take place to be successful in the programs, and the payoff from those investments comes a bit down the road," he says. "How can we promote and stimulate these investments in value-based care as the models are evolving?"

Figure 14 | **Please select the top three payment models that are most likely to evolve into one of your organization's principal payment models for value-based care.**



Base = 105, Multi-response

Taken as a whole, Ryu says the survey responses show that value-based care has gained a foothold, "but there's still many miles to go before we sleep."

"In some ways, COVID may have accelerated the recognition and an awareness, but there's still a lot of work because what we've seen is the beginnings of payment transformation," Ryu says.

"What we have not seen yet is a meaningful delivery system transformation. That's going to take more time and it's going to take more risk before providers have that right set of incentives to invest in the next delivery system models."

Ryu says the survey responses also suggest that providers may be presented with too many value-based care options.

"Sometimes, less is more. I do wonder if the attention for organizations is getting diluted over too many programs. You've got bundles, Medicare Shared Savings Program, pay-for-performance, etc. It's starting to feel like 31 flavors," he says.

"Sometimes, when your energy gets dissipated and diluted over so many options, I wonder if it is working against us overall in terms of focus and creating the right incentives and focusing on what kind of care models can really help to bend the value curve," he says.

He continues, "There's got to be enough value potential to incent people to come into the model. You need more people to make a more meaningful jump into the pool as opposed to just dipping their toe in the water."

Ryu says he empathizes with providers who are reluctant to take the plunge.

"It's a big change. This is not something that's easy to do," he says. "But that's why, from a policy standpoint, to get that uptake where people are jumping into the more meaningful models, there needs to be an impetus, whether that's mandatory or if the incentives are such that it makes it almost a no-brainer not to jump in."

John Commins is a senior editor for HealthLeaders. He can be contacted at jcommins@healthleadersmedia.com.

METHODOLOGY

The *HealthLeaders 2021 Value-Based Care Survey* was conducted by the HealthLeaders Intelligence Unit, powered by the HealthLeaders Council. It is part of a series of thought leadership studies. In November 2020, an online survey was sent to the HealthLeaders Council and select members of the HealthLeaders audience at healthcare provider organizations. A total of 105 completed surveys are included in the analysis. The margin of error for a base of 105 is +/- 9.6 at the 95% confidence interval. Survey results do not always add to 100% due to rounding.

What Healthcare Leaders Are Saying

Here are selected comments from leaders who say what new value-based initiatives their organizations are planning to implement within the next year.

"Payer-specific quality incentive plans for fee-for-service. ACO-specific upside/downside risk."

—Chief operations officer at a large hospital

"Moving our own self-insured health plan into a value-based model."

—Chief financial officer at a large health system

"Risk assumption, bundled payments."

—CEO/president at a small hospital

"Greater reliance on telehealth visits, greater use of research projects to inform quality outcomes and reduced cost, and greater awareness in the organization that we are shifting to new models."

—Chief quality officer at a large hospital

"Care coordination model."

—Chief medical officer at a large health system

"Episodic care: prospective bundles with two-sided risk. Medicare Advantage shared savings program with two-sided risk. Medicare direct contracting. Partial capitation."

—VP/director population health at a large health system

About the HealthLeaders Intelligence Unit

The HealthLeaders Intelligence Unit, a division of HealthLeaders, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

Vice President of Business Development/Publisher
RAFAEL CARDOSO
rcardoso@blr.com

Manager, Content
ERIKA RANDALL
erandall@healthleadersmedia.com

Research Editor
JOHN COMMINS
jcommins@healthleadersmedia.com

Intelligence Report Contributing Editor
CHRISTOPHER CHENEY
ccheney@healthleadersmedia.com

Senior Client Services Manager
JEFF KONYK
jkonyk@healthleadersmedia.com

Art Director, Intelligence Report Design and Layout
DOUG PONTE
dponte@simplifycompliance.com

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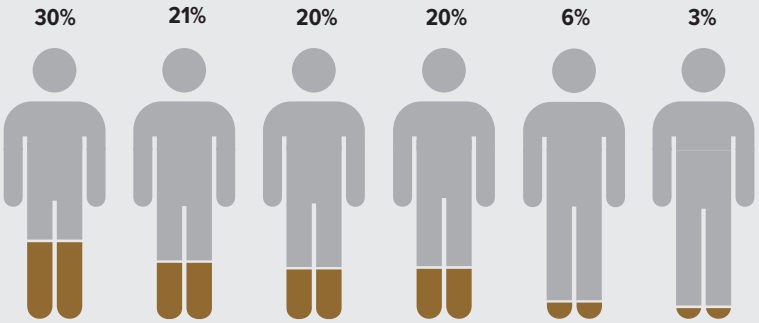
RESPONDENT PROFILE

TITLE

Base = 105



CEO, PRESIDENT

- CEO, President
- Chief Executive Administrator
- Chief Administrative Officer
- Board Member
- Executive Director
- Managing Director
- Partner

OPERATIONS LEADERSHIP

- Chief Operations Officer
- Chief Strategy Officer
- Chief Compliance Officer
- Chief Purchasing Officer
- VP/Director Operations Administration
- VP/Director of Compliance
- Chief Human Resources Officer
- VP/Director HR/People
- VP/Director Supply Chain/ Purchasing

FINANCIAL LEADERSHIP

- Chief Financial Officer
- VP/Director Finance
- VP/Director Patient Financial Services
- VP/Director Revenue Cycle
- VP/Director Managed Care
- VP/Director Reimbursement
- VP/Director HIM

CLINICAL LEADERSHIP

- Chief Medical Officer
- Chief Nursing Officer
- Chief of Medical Specialty or Service Line
- VP/Director of Medical Specialty or Service Line
- VP/Director of Nursing
- Chief Population Health Officer
- Chief Quality Officer
- Medical Director
- VP/Director Ambulatory Services
- VP/Director Clinical Services
- VP/Director Quality
- VP/Director Patient Safety
- VP/Director Postacute Services
- VP/Director Behavioral Services
- VP/Director Medical Affairs/ Physician Management
- VP/Director Population Health
- VP/Director Case Management
- VP/Director Patient Engagement, Experience

MARKETING LEADERSHIP

- Chief Marketing Officer
- VP/Director Marketing
- VP/Director Business Development/Sales

IT LEADERSHIP

- Chief Information Technology Officer
- Chief Information Officer
- Chief Technology Officer
- Chief Medical Information Officer
- Chief Nursing Information Officer
- VP/Director IT/Technology
- VP/Director Informatics/Analytics
- VP/Director Data Security

TYPE OF ORGANIZATION

Base = 105

Hospital	**45%**
Health System (IDN/IDS)	**32%**
Physician Organization (MSO/IPA/PHO/Clinic)	**17%**
Urgent Care Center	**1%**
Home Health Agency	**1%**
Skilled Nursing Facility/Nursing Home	**1%**
Payer/Health Plan/Insurer (HMO/PPO/MCO/PBM)	**1%**
Ancillary Services Provider (Diagnostic/Therapeutic/Custodial)	**1%**
Occupational Therapy	**1%**

NUMBER OF PHYSICIANS

Base = 105

1–9	**6%**
10–49	**10%**
50+	**83%**
N/A	**2%**

NUMBER OF BEDS

Base = 105

1–199	**22%**
200–499	**24%**
500+	**36%**
Do not have a standard number of beds	**18%**

PROFIT STATUS

Base = 105

Nonprofit	**68%**
For-profit	**32%**

NET PATIENT REVENUE

Base = 105

$1 billion or more (large)	**30%**
$250 million–$999.99 million (medium)	**17%**
$249.9 million or less (small)	**47%**
None of above	**7%**

RESPONDENT REGIONS