



Care Delivery Transformation: Four Levers to Enhance Value

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The unsustainable trajectory of healthcare costs, combined with limited improvements in the overall health of our population, has caused industry analysts to repeatedly express the need for a sweeping transformation of our nation's healthcare delivery system. Over a decade's worth of articles and reports have consistently made the case that United States citizens are not receiving a level of value commensurate with their expenditures on healthcare services. To address the issue, a sizable burden has been placed on providers to simultaneously reduce the cost, improve the quality, and

optimize the experience associated with the use of healthcare services.

While historically most provider organizations could point to their mission, vision, and value statements to show they were conceptually aligned with the achievement of these three objectives, the tangible business case for effectuating value-enhancing care delivery transformation remained weak in an environment of predominantly fee-for-service (FFS) reimbursement. Ultimately, under FFS reimbursement, even the most promising value-enhancing care delivery transformation initiatives were not financially sustainable, as the positive effects of capturing incremental market share were often counteracted



by reduced per capita utilization of a provider organization's services. As a result, many organizations did not fully commit to meaningful care delivery transformation. While the conceptual case for care delivery transformation captured their hearts, the financial business case did not clearly resonate in their minds.

However, since the Affordable Care Act (ACA) was passed in 2010, successive governmental legislation has placed increasing levels of financial risk onto healthcare providers. Most recently the passage of MACRA reaffirmed CMS's intent to move a majority of Medicare payments to alternative reimbursement models by 2018. Commercial payors are following

CMS's lead and are piloting a broad variety of value-based reimbursement models in markets across the country. As providers become increasingly financially accountable for the value of services provided to patients across a broader continuum of care, the conceptual and business cases for care delivery transformation begin to clearly align.

Regardless of what happens to the ACA, the transition of provider reimbursement from volume to value will continue to build momentum. As part of the restructuring of our nation's healthcare delivery system, increasing the value received for our healthcare dollars will remain a focal point. For that reason, care delivery transformation must be a top priority today.

THE VISION OF CARE DELIVERY TRANSFORMATION

From a patient's or payor's perspective, the vision for care delivery transformation is clear. Healthcare consumers (i.e., patients) and payors (i.e., commercial insurers, government, and employers) have explicitly tasked providers with increasing the value of the services they provide by achieving three noble objectives.

- 1** Reduce the per capita cost of healthcare services. In the short term, achieving this objective requires providers to remove waste (i.e., excess and inefficient utilization of services) from the healthcare value chain. In the longer term, realizing this goal obligates providers to also reduce errors of omission (i.e., not providing necessary healthcare services) that lead to disease progression, deterioration of health, and additional cost.

- 2** Improve the quality of care provided to patients. Realizing this objective requires providers to develop a holistic understanding of their patients' healthcare needs, craft personalized and evidence-based care plans, coordinate care across providers, en-gage patients in the management of their health, track patient compliance and clinical progress, and adjust treatment plans as necessary.

- 3** Optimize patient experience. This requires organizations to make clinical care more convenient, coordinated, and tailored to patient preferences.

In any industry, let alone one as complex as healthcare, it is clear that pursuing these three often conflicting objectives can be a daunting challenge. Simultaneously improving performance in each of these domains will inevitably require fundamental changes to traditional care delivery models.

CARE DELIVERY TRANSFORMATION LEVERS

Transforming traditional care models that were built to optimize throughput and maximize revenues in an FFS world to those that can deliver upon a value-based business case is no small task. With that in mind, ECG has identified four key areas where healthcare organizations should focus their care delivery transformation efforts to better position themselves as [value-based enterprises](#): clinical integration, expanded access, population health management (PHM), and practice redesign.

Clinical Integration

When care is not coordinated, quality of care, patient experience, provider satisfaction, and the value of healthcare services deteriorate. Today's fragmented care models are plagued by the over-, under-, inappropriate, and ineffective use of healthcare resources. Clinical integration strategies focus on the establishment of high-value provider networks and systems to efficiently coordinate services across sites of care. Often times these efforts are supported by investments in an

information technology infrastructure that enables the providers' ability to: communicate with other providers and patients; share pertinent clinical information within the network; maintain compliance with evidence-based guidelines and protocols; and track critical patient outcomes. Ultimately clinical integration initiatives position engaged providers to not only deliver but demonstrate high value healthcare. Housing these networks in accountable care organizations, clinically

Exhibit 1 — Clinically Integrated Care Models

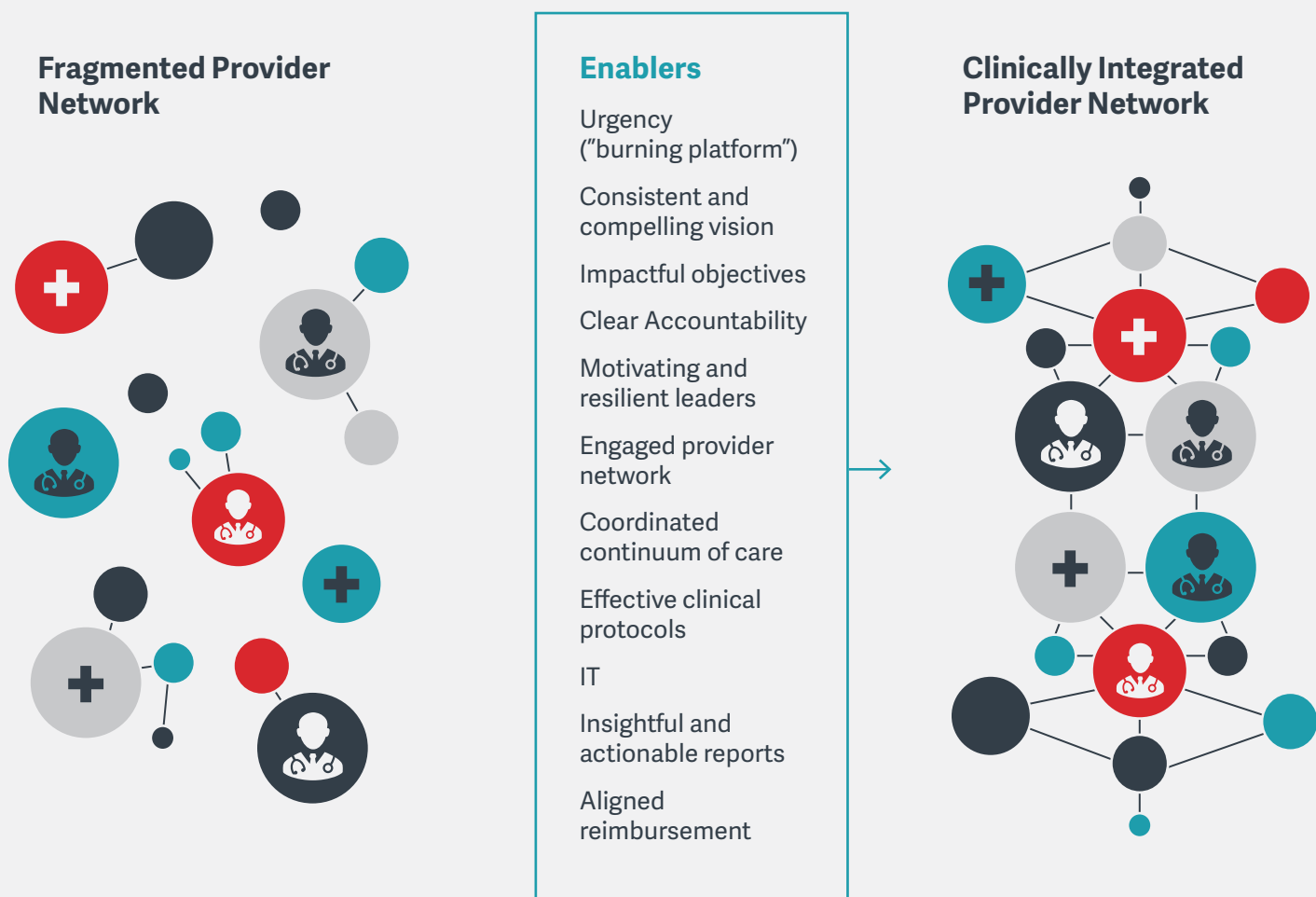
Clinical integration is a broad concept that can be interpreted and hence implemented differently depending on the vision of and the unique market pressures facing the organization. Several models exist for establishing integrated, value-enhancing provider networks including the following:

- **Clinically-Integrated Network (CIN):** A CIN is a network of providers who work together in a coordinated matter to consistently reduce costs and improve quality (e.g., using common protocols, measuring and tracking performance). Clinical integration underpins success under any integrated model, especially for organizations adopting risk-based reimbursement models.
- **Regionally-Affiliated Network (RAN):** A RAN is an affiliation of multiple health systems and their associated provider networks. This integration model may be appropriate for organizations that have a limited geographic footprint but want to expand their geographic scope and scale of their offerings.
- **Cross-Continuum Service Line:** This defines a service line that crosses over multiple sites of care, such as ambulatory, acute, and post-acute care. Developing cross-continuum service lines may be appropriate for health systems entering into bundled payment initiatives or those that are interested in increasing coordination for patients with a particular disease state (e.g., cancer, orthopedics, cardiology, etc.).
- **Accountable Care Organization (ACO):** An ACO is a network of hospitals and physicians who coordinate and deliver care for assigned beneficiaries and share in the savings and/or risk associated with caring for those beneficiaries. This model may be suitable for organizations that have a payor partner with a defined beneficiary population within the region and those who have begun to develop the capabilities to manage care across the care continuum.

integrated networks, regionally affiliated networks, or cross-continuum service lines (See Exhibit 1) can help healthcare providers to successfully finance their value-based transformation initiatives by taking advantage of shared service, joint contracting, and value-based reimbursement (e.g., bundled payment, shared savings, capitation) opportunities.

Clinical integration initiatives do not catalyze themselves. In addition to the enablers listed in Figure 1, these initiatives require a material commitment of time and resources both from sponsoring entities (e.g. hospitals, health systems, etc.), administrative leaders and direct providers of care.

Figure 1 — Catalyzing Clinical Integration



Expanded Access

Historically, patients have been obligated to meet their providers at a place and time designated by the provider. The fact of the matter is that when care is not convenient, it is often forgone. From a clinical perspective, provider-centric care models tend to be suboptimal in their ability to manage both acute and chronic illnesses, leading to deterioration in health status and an escalation of expenses over time. From a business perspective each forgone patient encounter results in lost revenue in the short-term and deterioration of loyalty to the relevant provider and the broader provider network in the longer-term.

Healthcare organizations preparing for value-based reimbursement need to embrace care models that may cause patients to defer care or seek it from competing organizations where the cost and quality of the care cannot be actively managed. Effective care delivery transformations require providers to both expand their access channels and to redistribute clinical services more effectively across traditional sites of care. A number of strategies being deployed across the country to provide patients with increased access to convenient, timely and effective care are depicted in Figure 2.

Figure 2 — New Access Channels



Population Health Management

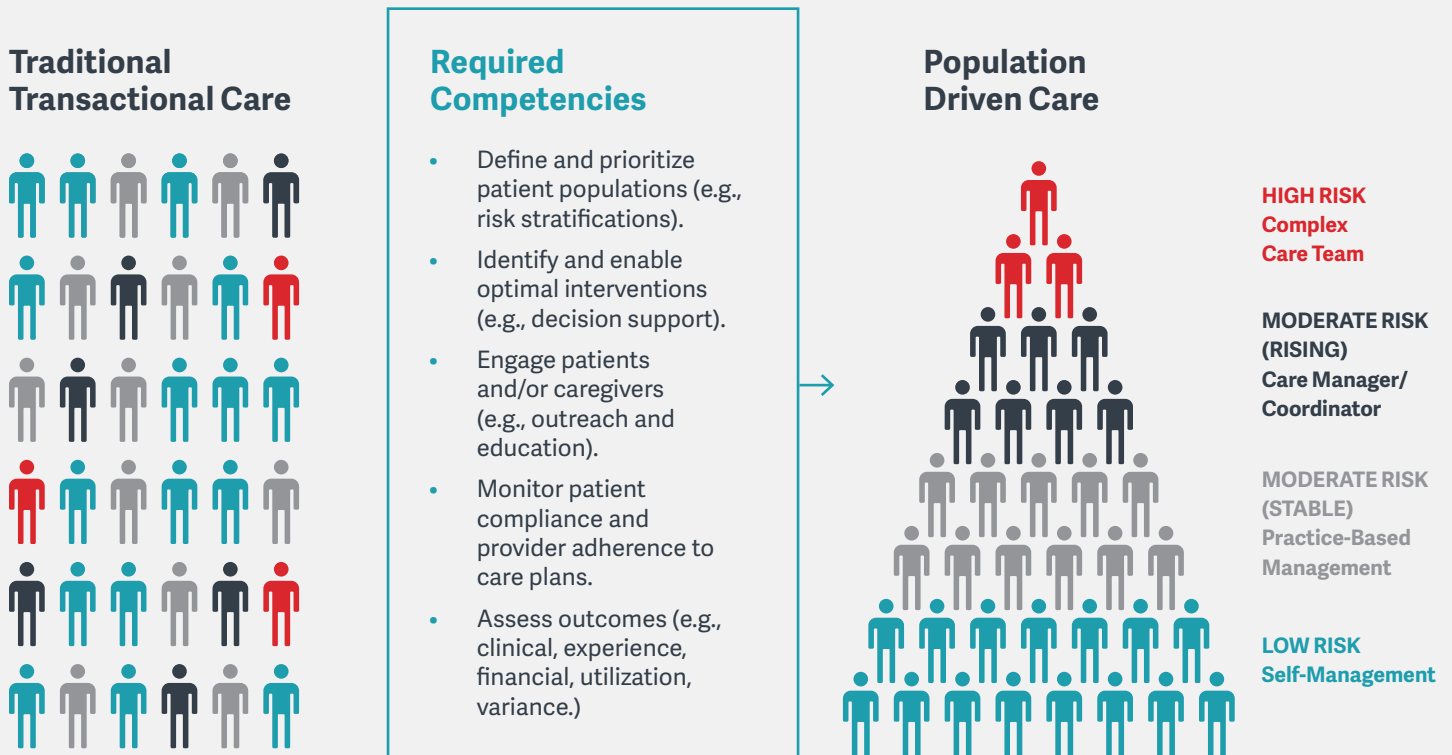
Although high-functioning transactional care models may adequately address patients' stated healthcare needs, they are not as effective at anticipating them. Retrospective patient activation results in missed opportunities to optimize health status and minimize disease burden. PHM strategies seek to pro-actively identify and address the healthcare needs of both defined populations and individual patients.

By implementing a valid risk stratification methodology (e.g. utilization, cost, diagnosis, risk factor, sociodemographic, or multi-factorial), patients can be more appropriately matched with clinical programs (e.g., wellness, risk modification, chronic disease management, complex care management, transitional care management, palliative care) that will benefit

them while allowing for a more efficient allocation of healthcare organizations' often limited resources. By ensuring that patients receive their medically necessary care, effective PHM programs may reduce patients burden of disease and long-term healthcare cost while generating incremental revenue streams for their sponsoring providers through both increased patient encounters and fee-schedule optimization resulting from increased performance on value-based payor contracts (e.g. pay-for-performance, shared savings, etc.).

Critical competencies that provider organizations must develop or acquire to successfully engage in PHM are listed in Figure 3.

Figure 3 — Managing Populations

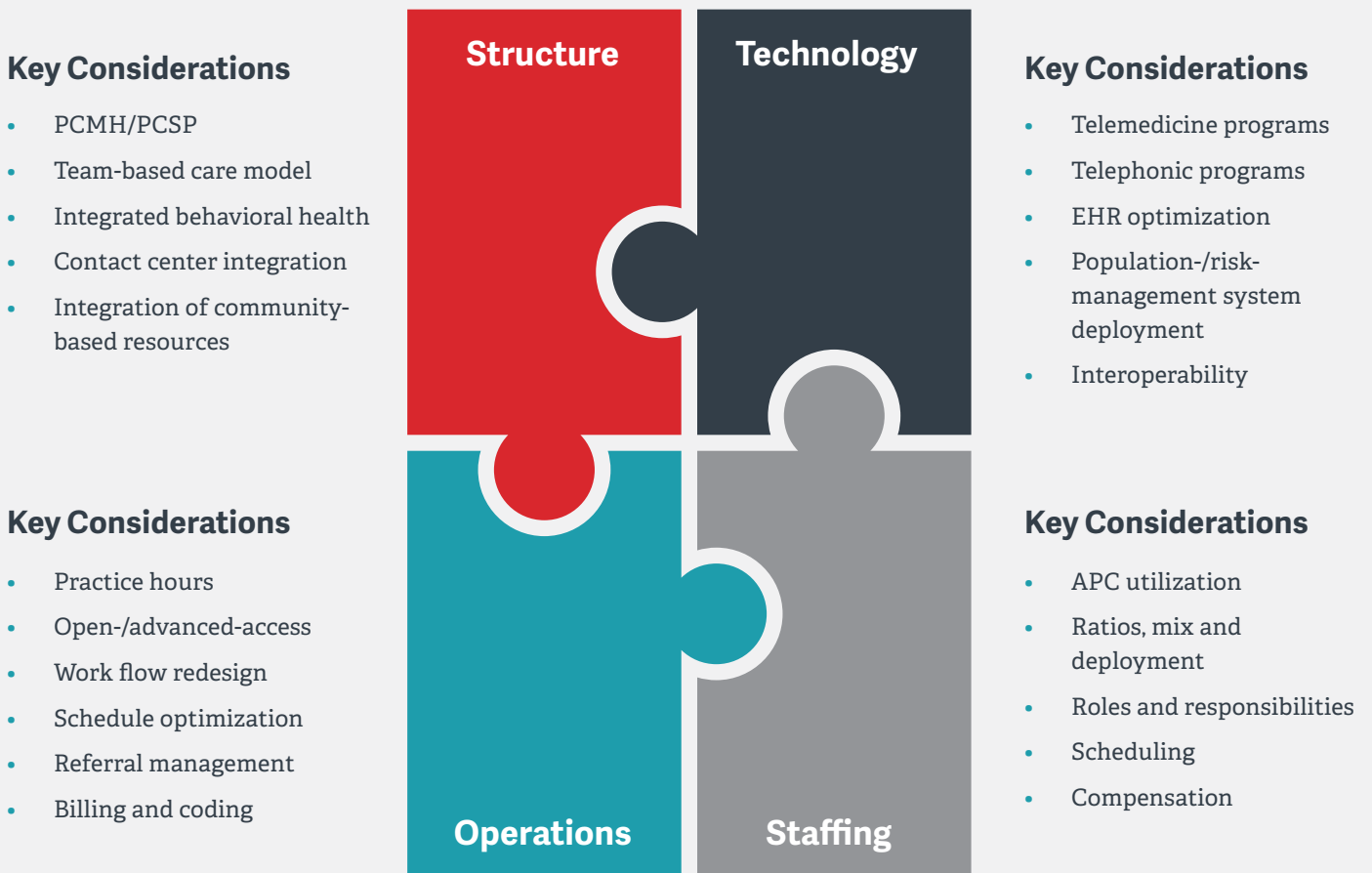


Practice Redesign

Traditional practice operations have failed to optimize outcomes, patient experience, throughput, and the deployment of human capital. To be successful under value-based reimbursement, practice, clinic, and hospital operations will have to become more efficient and flexible. In addition, practice redesign efforts will need to consider the optimal means of enabling other preceding, concurrent or planned care delivery transformation efforts (i.e. clinical integration, expanded access and PHM).

The focus and extent of the required redesign efforts will vary by organization but will likely require most healthcare executives to consider structural, technological, staffing, and operational changes including those presented in Figure 4.

Figure 4 — Components of Practice Redesign





EFFECTUATING SUCCESSFUL CARE DELIVERY TRANSFORMATIONS

Care delivery transformation is a significant undertaking. Most healthcare organizations lack the time, resources and energy to effectively pursue a “big bang” (i.e. taking on all components of the transformation at once) approach to care delivery transformation. Community needs, competitive pressures, consumer and payor expectations, available resources, institutional capabilities and organizational culture must all be taken into account when determining which initiatives to pursue, the prioritization of each initiative and the overall timing of the transformation.

Effectively syncing the pace of an organization’s assumption of contractual risk with its care delivery transformation underpins the sustainability of the transformation effort. Leading too far with either clinical or financial innovation can prevent organizations from realizing the full benefits of transformation. In instances where care model restructuring significantly out-paces the adoption of new financial arrangements, payors may reap free-rider benefits arising from decreased utilization while providers’ balance sheets weaken. On the other hand, if providers accept risk-based

contractual provisions their clinical programs cannot deliver on, their financial position may deteriorate so rapidly they cannot sustain the investments in care delivery transformation that will be required to succeed under value-based reimbursement.

Charting a path that will allow organizations to remain financially sustainable, let alone successful, in a value-based reimbursement environment may seem like an overwhelming undertaking for many healthcare executives. That being said, healthcare organizations that approach care delivery transformation from a strategic perspective (e.g. we need to establish sustainable value-based differentiation in our relevant market) tend to outperform those who adopt a more reactionary (e.g. we need to perform better under MACRA) approach.

While it may seem intuitive, it is worth reiterating that the leaders of the most successful care delivery transformations deploy a structured approach to: assessing, planning, executing, and evaluating the effort (See Exhibit 2 for details).

Exhibit 2 — Defining the Care Delivery Transformation Process



As part of this process, feedback loops will be important tools to link the execution and evaluation phases to allow for course correction in a constantly evolving competitive and regulatory environment.

Assess: Any care delivery transformation efforts should begin with a comprehensive assessment of the healthcare organization’s current and desired future state in order to determine the required scope and feasible rate change. Critical components of this assessment include evaluations of an organization’s: care delivery model; provider network; clinical and business informatics; payment models and organizational foundation (as described in Figure 5).

Plan: In the planning phase, transformational activities (i.e., to address identified gaps) should be prioritized and sequenced within a practical transition timeline. Example strategic priorities can range from furthering physician alignment in key service lines or developing statewide CINs to launching a provider-owned health plan. To do this effectively, leaders will need to establish a decision-making framework (e.g., anticipated impact versus anticipated cost/complexity) that will prioritize the various transformation activities that must be undertaken. Once priorities are established, they will need to be translated into a detailed implementation plan. Successful provider organizations craft flexible strategic plans that allow them to build and maintain momentum in pursuit of their desired value-based end state while remaining nimble enough to respond to local, regional, and industry “wild cards” that may be dealt at any point in time.

Execute: Thomas Edison reportedly said, “Vision without execution is hallucination.” When it comes to care delivery transformation, vision without execution can be a very costly hallucination. Making care delivery transformation a reality will require an approach to execution that mitigates potential risks and enables smooth transitions. In order to realize this vision: relevant stakeholders will need to be engaged; high-functioning teams will have to be assembled; accountability will have to be instilled; adequate resources will have to be dedicated; results will have to be monitored and communicated; and final adjustments will need to be made.

Evaluate: Care delivery transformation is a complex endeavor with many moving parts. This journey requires its sponsors to continuously monitor progress, navigate obstacles, and correct course. This will require leaders to determine what really matters (e.g., key performance indicators), identify to whom it matters most (i.e., key stakeholders), communicate performance effectively (e.g., meaningful and actionable reports), and deploy proven methodologies (e.g., Lean, Six Sigma) to deliver the desired results.

Figure 5 — Value-Based Readiness Assessment

	Traditional		Value-Based		Assessment
 Care Delivery	Fragmented, focused on acute needs, physician-centric, dictated by individual provider experience	→	Coordinated, comprehensive, patient-centered, evidence-based	→	<ul style="list-style-type: none"> • Care coordination • Standards and protocols • Patient engagement • Clinical innovation
 Provider Network	Built on referral relationships, dominated by specialists, located adjacent to hospitals, legally accountable	→	Built to meet population needs, primary care-driven, community-based, financially accountable	→	<ul style="list-style-type: none"> • Comprehensiveness • Level of integration • Extent of alignment • Provider accountability
 Clinical and Business Informatics	Decentralized, not reasonably comparable, Microsoft Excel-based, run as needed, retrospective, internally compared statistics-based, narrowly distributed, informative	→	Centralized, commensurable, automated, strategic, prospective, externally compared, trend-based, widely disseminated, actionable	→	<ul style="list-style-type: none"> • Infrastructure and support • Data integration • Analytic competencies • Reporting capabilities
 Payment Models	Predominantly FFS, volume-based, adversarial payor/provider relationships	→	Increasingly risk-bearing, value-based, collaborative payor/provider relationships	→	<ul style="list-style-type: none"> • Market opportunity • Payor readiness • Employer relationships • Risk-sharing experience
 Organizational Foundation	Segmented leadership, cost-conscious, reactionary, department, resistant to change, physician-informed	→	Cross-continuum leadership, margin-conscious, visionary, multidisciplinary, supportive of innovation, provider-led	→	<ul style="list-style-type: none"> • Financial feasibility • Structural compatibility • Cultural tolerance • Leadership commitment

The results of this assessment should be translated into gaps (i.e., a gap analysis) the organization must address during the planning phase.

CONCLUSION

Despite changes in the political landscape, momentum pushing healthcare from a volume- to a value-driven industry has been consistently growing since the turn of the millennium. The transition, which began in earnest with the passage of the ACA, has been reinforced by recent MACRA legislation and remains a priority in Washington DC. The next decade is likely to be one of the most turbulent eras in the history of the contemporary healthcare industry and almost certainly the most tumultuous period in the careers of modern healthcare professionals. Executives who rationally embrace change and continually evolve their care models to deliver increasing levels of value will be the most likely to survive and thrive in the era of accountable care; whether that accountability be to the market or to government regulators.

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