HiMS Health Information Management Systems

Staying Profitable In the Era of Value-Based Care

A White Paper

Triple Aim

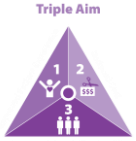
Ask 100 integrated health organizations how they're preparing to deliver Value-Based Care and most likely, you'll receive 100 different strategies back in return. When the set of performance-based payment criteria linking financial incentives to provider performance was originally proposed by CMS, there was no navigational roadmap included, so providers were left to fend for themselves in figuring out how to optimize their organizations to adapt to the new set of requirements and what exactly they needed to measure.

Determining out what to measure and how to deliver results to ensure the greatest positive impact on population and organizational financial health is daunting, to say the least. Aligning these two very different goals is just half the battle; ensuring measures are conducive to your population's conditions, obtaining provider engagement, identifying performance targets and using data to support and improve health also factor into the VBC equation.

When the Institute for Healthcare Improvement published *A Guide to Measuring the Triple Aim*, it provided a menu of outcome measures to help providers successfully navigate down the VBC road. The menu of measures was based upon a combination of analytical frameworks also outlined in further detail in the guide as well as real-world experiences of organizations that participated in the IHI Triple Aim prototype initiative.

Menu of Triple Aim Outcome Measures

Dimensions of the IHI Triple Aim	Outcome Measures
Population Health	**Health Outcomes:** • Mortality: Years of potential life lost; life expectancy; standardized mortality ratio • Health & Functional Status: Single-question assessment (e.g., from CDC HRQOL-4) or multi-domain assessment (e.g., VR-12, PROMIS Global-10) • Healthy Life Expectancy (HLE): Combines life expectancy and health status into a single measure, reflecting remaining years of life in good health
	Disease Burden: Incidence (yearly rate of onset, average age of onset)and/or prevalence of major chronic conditions
	Behavioral and Physiological Factors: • Behavioral factors include smoking, alcohol consumption, physical activity and diet • Physiological factors include blood pressure, body mass index (BMI) cholesterol and blood glucose (Possible measure: A composite health risk assessment (HRA) score)
Experience of Care	Standard questions from patient **surveys**, for example: • Global questions from Consumer Assessment of Healthcare Providers and Systems (CAHPS) or How's Your Health surveys • Likelihood to recommend



	Set of measures based on key dimensions (e.g., Institute of Medicine's six aims for improvement; safe, effective, timely, efficient, equitable and patient-centered)
Per-Capita Cost	**Total cost per member** of the population per month
	Hospital and emergency room utilization rate and/or cost

When examining high-performing organizations who have consistently delivered quality care at a lower cost, there are some common denominators which can be found. A 2014 report by The Rand Corporation entitled *Measuring Success in Health Care Value-Based Purchasing Programs* examined publicly available documentation from VBC programs as it related to ACOs, pay-for-performance and bundled/episode-based payments.

The study found that providers who were able to transform the way care was delivered to enhance performance demonstrated the following key factors to achieve success:

- An ability to rapidly learn and improve in order to achieve performance targets
- Promoting innovation, i.e., the creation of more integrated data systems to improve communication between providers, the development of care management protocols that carried across care settings, investments in registries allowing providers to track/better manage high-risk populations, developing and using risk assessment tools and the provision of clinical decision support
- Knowing the true cost of delivering care
- Having the appropriate infrastructure for quality improvement

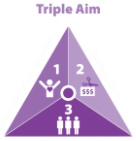
EHR systems play an integral part in helping to determine reimbursement based upon provider performance. Currently, Meaningful Use under CMS requires that EHR vendors be able to generate quality measures. Systems that free up the data for use in other ways, such as taking clinical and outcomes data and combining it with financial data help providers develop actionable insights.

According to the Institute for Health Technology, full embracement of value-based reimbursement requires several data-based strategies:

- Automate as much of population health management as possible while emphasizing human contact for high-risk patients

- Don't try to manage population health with an EHR alone, but use applications built for population health to help accomplish your goals

- Integrate claims data with clinical data to provide breadth, timeliness, and adequate detail for analytic purposes and find ways to obtain timely information from hospitals and health plans about admissions, discharges, and procedures



- Apply financial analytics to budgeting, using historical data on costs and, if possible, activity-based cost accounting

Success in value-based payment models necessitates financial investments by providers on many different levels, and can encompass new EHR and care management technology, the hiring of new staff members or the deployment of different types of billing methods to assist in compliance. Technology-based aspects of value-based payment programs involves how providers handle care coordination for their patients and claims data analysis, which is the backbone of all risk-based payments.

Reviewing all of the historical data on a patient allows for insight into where providers can pinpoint all cost-reduction efforts and what specific issues patients have that can possibly lead to increased episodes of care costs. Leveraging the data within the EHR via chart and claims review is a good starting point, but going a step further to obtain a complete view of payor claims data is imperative to gaining insight into what the drivers of cost are within an episode of care.

Another important aspect in value-based care programs is the role that patients and their families and/or caretakers play in mitigating costs and helping providers to meet the challenges of value-based reimbursement models. Ensuring that patient, payor and provider goals are aligned stems from designing interventions that take into consideration the impact on the patient's outcome as well as the health care system. Engaging patients to understand that they now play an integral role in helping to determine how their health care is delivered involves educating and setting expectations up front, especially before, during or after a hospital stay or surgery. Utilizing patient portals to enlist patients in communicating directly with physicians, linking their smartwatches and other medical devices to their portal account for instant condition updates can enable providers to monitor and respond to health needs in real time.

Staying profitable in the era of Value-Based Care is possible when providers understand the goals they're aiming to achieve, the resources needed to carry them out and the best conditions for implementing their VBC program. Creating a value-based culture involves aligning all stakeholders, an investment in new technology and creating engagement points for patients to become actively involved in improving their own health care.