WHERE HEALTH SYSTEMS ARE IN THE SHIFT TO VALUE: FOUR CATEGORIES

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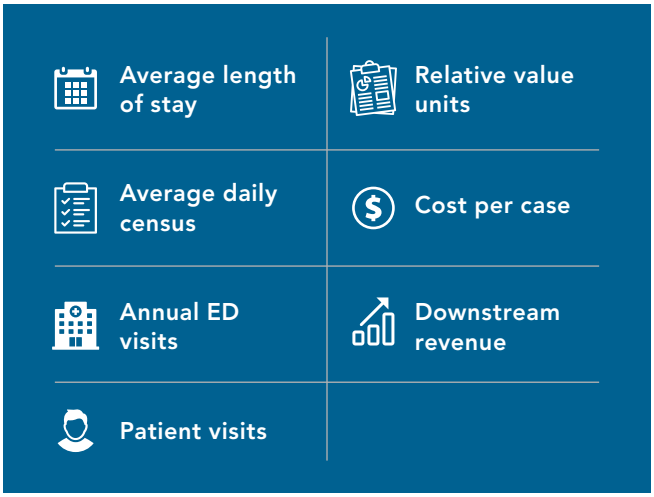
One could make the argument that there are four situational categories under which all health systems now fall on the journey toward more value-based care and away from the fee-for-service model. Assisting health systems in successfully transitioning to value-based care and delivering improved clinical and financial outcomes for their patient populations depends on very different approaches depending on where they fall on the spectrum. Appreciating these differences is critical to understanding how to approach each group of health systems when articulating value to achieve high-quality clinical and financial outcomes.

Health systems are at varying stages and levels of focus when it comes to shifting their care delivery to a model emphasizing value. Although many health systems have painted a rosy picture of their transition from fee-for-service (FFS) to value-based care, the reality of the situation is far different. One could make the argument that there are four varying situational categories under which all health systems now fall. Some health systems are still firmly grounded on the FFS deck, while others have made it into the value-based boat. Many believe that most health systems fall somewhere in between—with one foot on the dock (FFS) and the other on the boat (value-based care), straddling the space in between. There is also a fourth scenario in which a health system has failed to transition, figuratively falling into shark-infested waters, where some systems will go under/die out naturally and others will be eaten by the competition. It is important to appreciate each of these four situations to better understand how to approach a health system regarding value so as to produce the highest level of clinical and financial outcomes.

Grounded on the FFS Dock

Despite the fact that the world has been fixated on the shift to value-based care for some time now, there are several types of health systems that are content with being firmly grounded on the FFS dock. This includes for-profit hospitals and those fortunate enough to be considered designation health systems that can demand what they want due to their prestige, such as the Hospital of the University of Pennsylvania and the Children's Hospital of Philadelphia, for example. Because these health systems are such a draw to patients, they can simply focus on their volume and demand whatever price is needed to cover their costs plus. As a result, these systems focus on volume and their costs of operation in areas such as length of stay; they are not at all focused on investing in efforts to reduce readmissions or keeping patients out of their beds, as this is solely where their revenue is generated. Value to these health systems is defined as filling their beds and reducing their cost of care **(Box 1)**. Other objectives are not priorities for these systems and, as such, value must be articulated to them purely in these terms. These health systems will be rarer in the future, but some may survive the transition to value-based care because they are seen as a valuable part of the current health care system that provides superior specialized care to unique populations.



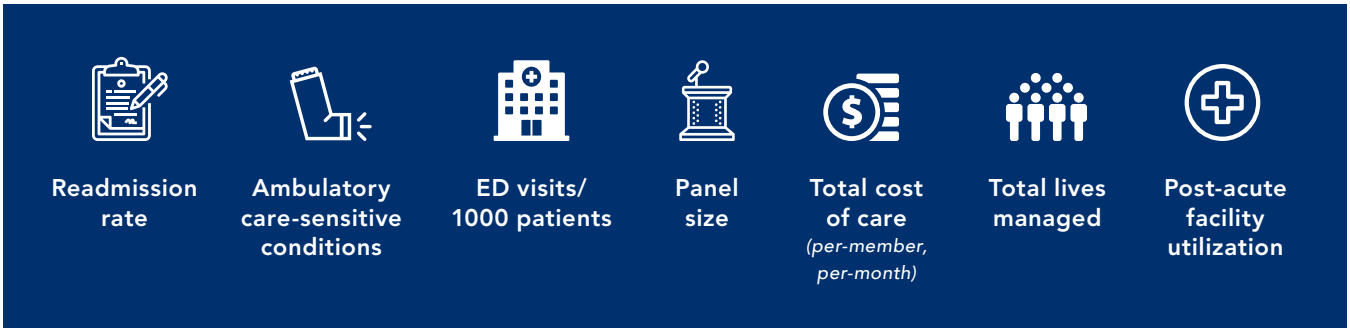
Box 1: Fee-For-Service Measures of Value

In a Shaky Value-Based Boat

Some health systems have boarded the value-based care boat; however, the stability of this situation is highly variable based in part on those value-based contracts signed and their ability to deliver on clinical and financial outcomes. These systems are focused not on filling their beds but rather the exact opposite—keeping individuals healthy far outside of their walls. For systems like Kaiser Permanente, which has been in the full-risk provider

game for years, the boat appears to be fairly stable. Changes in the healthcare system that require improving the health of members benefit full-risk providers like Kaiser, thanks to programs that focus on the most common chronic diseases to prevent filling hospital beds. With this model, all decisions are not only clinical but also financial, and the goal is to maximize value through overall cost of care rather than maximizing patient health outcomes in all circumstances. Some may question the greater number of more specialist providers, as they may be seen as a cost driver in a full-risk model. The Mount Sinai Health System (New York, New York) illustrated the priorities of systems implementing value-based care in an ad with the caption, "If our beds are filled, it means we've failed."[1] Quite the opposite view from those standing on the FFS dock.

For full-risk providers, the focus is on total cost of care, so investing to decrease their service volume is critical. Articulating value to these health systems means focusing on reducing total cost of care in areas such as prevention, delaying initial admissions, and reducing readmissions **(Box 2)**.



Box 2: Value-Based Care Measures of Value

An important point to consider is that health systems that follow the FFS model and those that focus on value-based care share one common area of focus: market share. Both groups are interested in capturing as much of the market as possible, since their revenue stems from their market volume.

Straddling the Two Worlds of FFS and Value-Based Care

There are, of course, health systems that are not fully on the FFS dock or firmly in the value-based boat, but instead find themselves straddling these 2 worlds. These health systems, such as Jefferson Health (PA/NJ), find themselves growing through hospital acquisitions, as well as by purchasing their own health plans. This situation takes providers like Jefferson Health and places them in the dual role of payer as well. Such health systems face a conflict between filling their beds and investing in keeping individuals healthy in the community; finding a balance between the two can be especially difficult when these systems find themselves investing in efforts that reduce their revenue. Articulating value to these systems depends greatly on whom one is speaking to. For example, the pharmacy group may be siloed as being responsible for drug costs. But if they are armed with information on the impact of increasing the pharmaceutical spend that would reduce their total cost of care, they could win the argument with their chief financial officer and medical director—although this can be an uphill battle at times. These organizations are preparing to make a successful transition from FFS to value-based care, while finding a balance between maximizing care from specialists and primary care providers within the health system.

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Falling in the Water

Finally, there are those health systems that will not succeed in the current shifting environment. Instead, they will fall into shark-infested waters where competitors will be looking to gobble them up in an acquisition or they will simply "die." Systems like rural hospitals or those like Hahnemann University Hospital (Philadelphia, Pennsylvania), which have failed to exist in either the FFS or value-based worlds,[2] may fail primarily due to their payer mix. Alternatively, systems may invest heavily in value-based care but fail to achieve cost savings—they only spend funds to reduce their revenue and do not receive savings—or worse, they may have to write a check to the Centers for Medicare & Medicaid Services (CMS) for spending above their benchmark. It is especially difficult for health systems that remain operationally focused on hospital revenue while still taking on risk. Then there are those health systems that own their market. These health systems may be forced to reduce their revenue to achieve reductions in total cost of care. It will be much easier on those health systems that can reduce other health system use for the patients for whom they are responsible, thus cutting others' revenue rather than their own, gaining a percentage of these savings.

Unfortunately, failing health systems will be more prevalent given the ever-increasing risk levels in the face of higher Medicare Part B expenditures, especially for new innovative biologics that have not been calculated into the benchmark total cost of care. As a result, through no fault of their own, simply providing appropriate use of a new diagnostics or treatment could force these health systems to miss their target and, as a result, write a check to CMS. Other factors forcing these failures is the fact that patients are becoming increasingly demanding even while being limited in their own ability or desire to manage their health. This increased demand in the face of crumbling support around social determinants of health is forcing some health systems to fill an increasingly widening gap without being reimbursed for these services.

The other reasons for these failures has been described by The Institute of Healthcare Improvement (IHI), which grouped these failed change efforts into 3 categories: failure of ideas, failure of will, and failure of execution.[3] The failure of ideas refers to the situation where ideas fail because they do not effectively diagnose the problem or generate a set of solutions that would work. Failures of will occur when everyone, from leadership to front-line staff, lacks the motivation to effectively engage in the process of developing and implementing solutions. Finally, the failure of execution occurs when new solutions are not implemented in a way that works.

For these systems, avoiding the failures of ideas, will, and execution may be too difficult, too little, or too late. Supporting them requires the knowledge and tools to ensure successful action; despite these efforts, many will fail. The only opportunity for outsiders is to stand on the sidelines to see how these systems are acquired, or if they are not acquired, to determine how their failure may impact nearby systems with a domino effect of more failures in systems that are unable to adapt.

Successfully Making the Move to Value

So how does a health system successfully make the move from FFS to value-based care? While it is too late for those that have already failed, there are still those that are caught between the two worlds of FFS and value-based care; they will either fail completely or retreat back to the safety of the dock—at least for now.

For these health systems to succeed, successful execution of Kotter's 8-step change process is required.[3]

These 8 steps include the following:

1. Establishing a sense of urgency
2. Creating the guiding coalition
3. Developing a vision and strategy
4. Communicating the change vision
5. Empowering employees for broad-based action
6. Generating short-term wins
7. Consolidating gains and producing more change
8. Anchoring new approaches in the culture

Wagner's Chronic Care Model provides an outline of how systems can integrate these steps into care delivery.[4] Under this model, health systems can move toward value-based care delivery by implementing the following tactics:

1. Making changes in organizational leadership, with senior-level leadership across medical and social sectors establishing the working relationships necessary to improve the safety, quality, and care experience for patients
2. Establishing links with community-based resources to bridge healthcare and social service sectors
3. Implementing effective self-management support to promote evidence-based models, where providers and patients work collaboratively toward patient goals
4. Redesigning the delivery system to allow for adoption of evidence-based models and integration across care settings
5. Using evidence-based decision support to ensure adherence to the best available evidence for patient care
6. Improving information systems for the collection of meaningful data and sharing of data across collaborators

An example of these principles being put into action can be seen in the work of Bill Frist, MD. With a strong background in health systems as a heart and lung transplant surgeon and founding family of Hospital Corporation of American as well as policy expertise as a Senator Majority Leader from 2003 to 2007, Dr. Frist was well equipped to establish the not-for-profit organization NashvilleHealth with a mission to substantially improve the health and well-being of Nashville, Tennessee, residents. With the goal of value-based population health, NashvilleHealth established the objectives at **Table 1**, achieving these by tracking against specific measures.[5]

OBJECTIVES	MEASURES
1. Convene diverse groups of key local stakeholders 2. Identify specific and measurable community health indicators 3. Develop a comprehensive and practical health roadmap 4. Leverage and align Nashville's relevant resources (ongoing) 5. Engage academic partners to measure ad monitor outcomes 6. Strengthen the community-wide integration of health services 7. Scale evidence-based, countrywide success to state and national level	• Adhere to the Office of Disease Prevention and Health Promotion's Health People 2020 goals, with a 2022 goal date for NashvilleHealth • Create specific equity goals for each area of focus to reduce racial disparities and create a culture of health citywide • Consider process metrics, such as the number of individuals or grips involved in the work, along with media reach • Develop processes for measuring the quantifiable outcomes of each individual program as they are developed for each focus area

Table 1: NashvilleHealth Objectives, Measures for Improving Nashville Population Health

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Final Thoughts

Assisting health systems in successfully transitioning to value-based care and delivering improved clinical and financial outcomes for the population they care for depends on very different approaches depending on where they fall on the spectrum. Appreciating these differences is critical to understanding how to approach each group of health systems when articulating value in order to produce the highest level of clinical and financial outcomes. It is not an easy journey from the safety of the dock to getting into the boat—without help, many will fall.

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