DRIVING SERVICE LINE PERFORMANCE AS A PLATFORM FOR GROWTH:

Structuring Effective Hospital and Physician Partnerships to Improve Quality and Efficiency

HEALTHGROUP WEST

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Catalysts for Change

In 2018, the medical cost trend is projected to rise, bucking a three-year declining trend that had been attributed to the adoption of value-based care models, improved care management, and a shifting of the cost burden to consumers.[i] Additionally, healthcare costs continue to outpace both inflation and wages, suggesting health reform remains a critical but largely unfinished business made even more uncertain by recent shifts in legislative and regulatory direction.[ii] Back on "Main Street," however, employers haven't waivered. They continue to push for increased adoption of alternative payment models that demonstrate value in terms of both dollars and health outcomes[iii] and to seek out partners that share their priorities. And, the payers competing for their business continue to do the same. Not only is delivering value-based care central to the mission of many, if not all, healthcare operators, it is increasingly a critical platform for market share growth in the form of direct to employer contract models, access to preferred partnership opportunities and success in consumer-driven healthcare.

So, how does a hospital become the preferred partner for local employers and payers seeking value?

1) They can objectively demonstrate positive health outcomes, equal to or better than competitors.
2) They can deliver their services at a lower price to the employer.
3) They offer convenient, multiple locations of care for employees.
4) They provide access to a "one stop shop" for all employers' healthcare needs (inpatient, outpatient, urgent & emergency care).

This sounds simple enough yet there are many barriers to success including the sheer number and variety of pay for performance programs under individual payers, the complexity of obtaining data from sophisticated EMR systems, and the need to engage partners who often lack incentive to contribute time and expertise to time-consuming and complicated improvement efforts.

Aim for the Right Target: Quantify the Gaps

For many hospitals and physician groups, the starting point for mutual success in value-based payment models will be quantifying the opportunity. This should include a hard cost opportunity (in the form of pay for performance and value-based payments) and a soft cost opportunity (in the form of ratings and rankings that will impact consumer preference for the organization's services):

(1) **Create a Q-GAP Report.** The Quality Goals and Perceptions (Q-GAP) Report will help identify key gaps that must be addressed to achieve pay for performance and outcomes goals and impact consumer preference for your organization. Begin by taking an inventory of all the quality and performance metrics that underpin your current pay for performance and value-based payment contracts, and those which impact your publicly-reported quality ratings and rankings. There is often a great deal of overlap in the metrics utilized by various payer programs, which means that performance can have a compounding effect, positively or negatively. Include any future indicators that have been announced but which are not yet impacting payment calculations and begin to track them immediately, giving the team an opportunity to improve performance prior to the reporting period.

Present the most recently reported data for incentivized and publicly reported quality metrics and consumer preference alongside data for your local competitors if it is also publicly available.

Figure 1: Sample Q-GAP Report

		COMPETITOR HOSPITAL	BEST HOSPITAL IN STATE	5 STAR HOSPITAL*	YOUR HOSPITAL
		10/01/14-09/30/15	10/01/14-09/30/15	10/01/14-09/30/15	10/01/14-09/30/15
	HOSPITAL COMPARE DATA	****	****	*****	***
35	Average (median) time patients spent in the emergency department before they were seen by a healthcare professional	9 Minutes Other Medium volume hospitals: Nation: 24 Minutes	77 Minutes Other High volume hospitals: Nation: 28 Minutes	25 Minutes Other Very High volume hospitals: Nation: 32 Minutes	44 Minutes Other High volume hospitals: Nation: 28 Minutes
36	Patients assessed and given influenza vaccination	99%	89%	95%	94%
37	Healthcare workers given influenza vaccination	89%	79%	89%	91%
38	Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started	N/A	85%	N/A	80%
39	Ischemic stroke patients who received medicine known to prevent complications caused by blood clots within 2 days of hospital admission	95%	98%	95%	97%
40	Ischemic or hemorrhagic stroke patients who received treatment to keep blood clots from forming anywhere in the body within 2 days of hospital admission	100%	97%	99%	96%
41	Ischemic stroke patients who received a prescription for medicine known to prevent complications caused by blood clots at discharge	100%	99%	100%	99%
42	Ischemic stroke patients with a type of irregular heartbeat who were given a prescription for a blood thinner at discharge	N/A	96%	100%	98%
43	Ischemic stroke patients needing medicine to lower bad cholesterol, who were given a prescription for this medicine at discharge	98%	98%	100%	95%
44	Ischemic or hemorrhagic stroke patients or caregivers who received written educational materials about stroke care and prevention during the hospital stay	100%	92%	98%	98%
45	Ischemic or hemorrhagic stroke patients who were evaluated for rehabilitation services	97%	97%	93%	96%
46	Patients who got treatment to prevent blood clots on the day of or day after hospital admission or surgery	100%	93%	98%	87%

Where possible, quantify the financial value of those metrics which are not being achieved (e.g. what's being left on the table) and use this information to help prioritize areas of focus and resource allocation. Similarly, consider the potential impact of poor ratings and rankings on consumer preference and market share. While public ratings and rankings have their limitations, they are increasingly utilized by patients in selecting a provider.[iv], [v] A 2015 study by National Research Corporation found that 70 percent of consumers would like to see performance data before choosing a healthcare provider and 43 percent of consumers currently in need of a doctor plan to use online reviews and ratings to find one.[vi] It is imperative that hospital and physician leaders do not discount these more subtle impacts to performance.

Figure 2: Example of Opportunity Calculation

	Eligible Not Earned 2016	Eligible Not Earned 2017	2-Year Missed Opportunity
Payer 1: Pay for Performance	$934,749	$834,234	$1,768,983
Payer 2: Pay for Performance	$628,970	$756,340	$1,385,310
CMS VBP	$574,260	$843,013	$1,417,273
PQRS	$335,000	$210,439	$545,439
TOTAL	**$2,472,979**	**$2,644,026**	**$5,117,005**

Build the Team

Armed with a clear understanding of the opportunity, engage leaders from across the organization in addressing it. This team should involve disciplines traditionally associated with quality improvement such as Quality, Performance Improvement, Nursing, Physician Leadership (from primary care and key specialties), Data Analytics and Administrative Leadership. Also consider adding non-traditional participants such as Coding and EMR Programming because quality metric scores can be influenced by coding (selection) and documentation (scoring). The work of this team should focus on hardwiring best practices and processes and aligning incentives to drive change necessary to maximize at risk compensation and position the organization within an acceptable tier of publicly reported ratings and rankings.

Application: When Best Practice Clinical Care Earns Low Quality Ratings

A multi-hospital system in the Midwest applying the Q-GAP approach to improve their publicly reported quality metrics determined via chart review that fully 25% of cases not meeting quality standards were attributable to insufficient documentation. The team worked with the EMR Programming department to develop alerts for patients meeting certain criteria and with Coding personnel to ensure that team was aware of tracked conditions. Documentation related fall-outs declined immediately resulting in a significant improvement in pay for performance achievement.

Align Incentives

Physician engagement will be critical to achieving sustainable improvements in clinical quality and value-based care delivery. Yet, physicians have many competing demands on their time and may be hesitant to take time away from patient care for what appears to be an administrative project. If being a top performer in terms of quality will positively impact the organization's ability to capture unrealized pay for performance incentives and better position the organization to gain market share by competing on value, then the time and expertise physicians lend to achieving the improvements has real and substantial value to the organization and they should be compensated for their time and/or achieving the milestones accordingly. Of course, quality-based incentive programs are nothing new. And there are countless examples of poorly

structured programs that fail to generate results due to apathy around the incentive or a failure to select targets that result in meaningful change for the organization. Numerous studies have demonstrated that simply tying individual financial incentives to outcomes or performance metrics does not necessarily produce results and in some examples, can strain the relationship between hospitals and physicians.[vii] Organizations should take the following steps to structure a mutually-effective incentive program:

- **Focus the Effort.** Payors, public rating sites, and other healthcare agencies are tracking hundreds of discrete metrics. While the sheer volume is enough to dilute efforts, even more frustrating for providers is the fact that the various agencies often use similar data to arrive at conflicting conclusions around the quality of care provided. A 2007 study found that, "no hospital was rated as a high performer by all four national rating systems." And, "only 10 percent of the 844 hospitals rated as a high performer by one rating system were rated as a high performer by any of the other rating systems." [v] Advocate Health System's highly-touted accountable care organization has had some success in leveraging their network's scale and track record to work with payors and other agencies to identify a common list of metrics to track and incentivize which has allowed the ACO to focus its improvement efforts. Short of this approach, organizations should consider metric pay for performance weight and consequent value, the frequency of a metric's utilization by multiple payors and ranking sites, and the organization's ability to impact the metric to focus the work effort to determine an initial list of 4-5 work areas. Limiting the focus will also ensure achievement incentives remain substantial for each metric.

- **Set Stepwise Improvement Targets.** Setting realistic targets for the improvement effort is just as important as having a manageable scope of work. In August of 2016, Doctors at NYC Health & Hospitals took their frustration with that health system's quality compensation program to the press, citing concerns with the program's implementation and what they deemed to be unrealistic targets tied to compensation. While the doctors agreed that the concept of tying the hospital's risk-based compensation to the physician's individual compensation was not inherently unfair, they noted that the goals established by the health system were in some cases well above current performance, making it unlikely that the incentive could ever be earned.[viii] While it is always important to keep the end goal in mind, setting stepwise improvement targets that begin to close that gap will often motivate group performance more effectively than an initial target that appears unachievable.

- **Balance Individual and Collective Success.** Even if the scope of work and stated goals are achievable, they may still fall flat if they are not deemed to be financially worthwhile uses of time and resources, particularly for physicians. Physicians are facing new and unprecedented demands on their time and practice resources outside of direct clinical care. A recent time and motion study of providers in four specialties suggested that for every hour of direct clinical care provided, an additional two hours is spent on EMR documentation and other clerical work.[ix] With so many competing demands for time and resources, organizations must balance individual and collective reward as they design financial incentives for quality improvement at the provider

level. The value of the incentive must be significant enough to motivate participation and the provider must have the opportunity to influence a substantial portion of the potential payout by their individual behavior. In addition, the incentive must encourage improvement as a group, motiving the group to hold individuals accountable to the group's overall performance.

- Establish a *Performance Management Agreement.* One model for addressing these common pitfalls is the development of a *Performance Management Agreement.* Typically, a contract between physicians or a physician organization and a hospital or health system, the *Performance Management Agreement* is an accepted partnership model that compensates participating providers for time and/or achievement of a defined set

Performance Management Agreements **have a high potential for success because they:**

- **focus program development, care transformation and quality improvement efforts across the sponsoring organization by facility, service line, or service,**
- **engage both independent and employed providers,**
- **streamline often ineffectual and/or uncoordinated medical directorships and quality bonus programs, and**
- **tightly align organizational and provider outcome goals, positioning the organization to maximize pay for performance revenue and generate new business as a result of demonstrated performance.**

of participation, clinical and performance outcomes for a particular service line (or entity). The opportunity is to ensure perfect overlap between the incentive metrics in the agreement and those included in the sponsoring organization's at-risk contracts (and for self-funded organizations, often metrics associated with their health plan), so the *Performance Management Agreement* can be self-funding. In addition, the *Performance Management Agreement* can replace all other medical directorships, quality bonus or incentive payments in individual contracts throughout the service line, ensuring care transformation and quality improvement efforts are focused and the administration of contractor payments is streamlined.

Resource the Model. Even with strong provider participation, a *Performance Management Agreement* will not succeed without appropriate structure and resources. Management must work collaboratively with physician participants to develop an

annual workplan that reflects shared goals, and which prioritizes efforts that will have a financial and clinical quality impact. To support the workplan, participating providers need access to real time data around key metrics and detailed analysis to understand and respond to underlying drivers of outliers. Typically, these resources are provided by the sponsoring organization and should be factored into the cost of deploying the *Performance Management Agreement.* Given the substantial dollars most organizations are leaving on the table from at-risk contracts each year, the investment in both the *Performance Management Agreement* and the resources needed to support it are typically more than offset by the Program's ability to improve performance and capture a higher percentage of at risk payments, even before growth opportunities are quantified.

Establishing a Performance Management Agreement is the easy part. Many Performance Management contracts fail because they have not been assigned an appropriate level of leadership support or because they do not manage time allocation and milestone planning effectively. The implementation of relevant agendas and the support of experienced leadership often makes the difference in driving outcomes which lead to success in these types of agreements.

Common Pitfalls:

- Making the committee / meeting structure too complex.
- Failing to develop an annual workplan and monthly agendas.
- Not managing agendas effectively to drive deliverables and outcomes.
- Lack of dedicated, seasoned administrative resources.

If your organization is interested in *driving performance as a platform for growth* and you need assistance with analysis, structure and implementation, please contact us to schedule an initial consultation:

CONTACT US:

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