



A 3D model for value-based care:

Care provider perspectives

Authored by
**Lucy Parker, Senior Partner,
Brunswick Group**

In collaboration with:

 **UnitedHealthcare**[®]

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Executive Summary

Care provider perspectives

Care providers are at the very heart of delivering on the potential of VBC, so it is crucial to understand how to make it work for them. Senior leaders from four care providers participated in interviews to accompany Harvard's systematic review: Mount Sinai, Ballad Health, Catalyst Health Network and Rhode Island Primary Care Physicians Corporation (RIPCPC).

The perspectives of all these providers reinforce the central proposition of Harvard's study that delivering on the promise of VBC means looking beyond the focus on financial incentives to a greater understanding of the 3D model. They agree that payers have a major contribution to make through non-financial infrastructure supports. Indeed, they go further: they view these as essential enablers to their ability to deliver the changes needed in their organization structure and care delivery model.

Across these different types of physician and health system leaders, five common themes emerge that inform thinking about the next frontier in VBC.

1. Value-based programs require substantial organizational change

Delivering on VBC requires constructing an entirely different type of organization. Every detail of the day-to-day running of provider operations needs to be reconfigured to deliver on this new model:

- In making this long transition, they all cite the proliferation of mismatched measures as one of the greatest challenges they face and a drain on their resources – as highlighted by Harvard's recommendations.

2. Shared data is the foundation of successful VBC relationships

The providers affirm Harvard's proposition that data sharing is a powerful mechanism for rebasing payer-provider relationships positively; the key to defining shared plans and goals:

- Yet there is a high degree of frustration about how this works in practice today, with each payer supplying data in different ways – and lack of timeliness which reduces its potential value significantly.
- Mount Sinai stands out as an organization with experience of writing into their contracts what data will be provided and when, underscoring how they see it as integral to successful delivery.

3. Increased capacity in care management strengthens their practice

Across all types of provider organizations, expanding resources in care management (in its various forms) is seen as one of the great practical benefits of shifting to VBC:

- For physicians, this is a tangible benefit for their patients, an expansion of their own working capacity and an improvement in the effectiveness of their entire practice.
- The greatest area of contention is whether these roles should be delivered by the provider or the payer, with the providers believing strongly this is an extension of care that they are best positioned to deliver.

‘Value-based care requires you to create a completely different type of organization.’

4. Resetting provider-payer relationships unlocks innovative program design

As part of establishing successful VBC arrangements, these providers have achieved a profound shift in their working relationships with payers – that they describe as ‘transformative’ or even ‘heart-warming’:

- The new mindset is symbolized by the commitment of all parties to ‘sit down’ together – payers and providers, sometimes with employers – with a determination to take a long view and identify mutual wins.
- The opportunity for ‘collaborative design’ is considerable – typically on focused, purpose-built projects that allow them to create all aspects of the desired outcome together, from scratch.
- These care providers also suggest that payers have a key role to play in the success of VBC by guiding consumer behavior through product design. They believe this would result in better utilization of healthcare resources and better health outcomes for their patients.

‘There’s a ton of common ground if you’re willing to look for it.’

5. Leadership commitment and stamina are critical success factors

All these organizations encounter internal concern and resistance because the journey is long, the degree of organizational change is enormous, the investment is significant and the risk is real. For all those reasons, they highlight the commitment and staying power of leadership as a primary driver to success:

- They all dedicate a significant amount of their time to winning the hearts and minds of their people – and sharing success stories is their strongest asset.
- Embedding physician leadership has proven to be valuable in sustaining momentum.
- Their insights reinforce the point made in Harvard’s study that while VBC remains only a small part of the overall payment regime of an organization, it cannot reshape the culture. To be effective, it has to reach further into the organization – even potentially to the physicians themselves.

All the leaders participating in this study have been working in pursuit of VBC for many years. Though their experiences underline the challenges involved, they say it is worth it and necessary. They are motivated by the opportunity to design a more aligned health system.

‘It gives us a once in a lifetime opportunity to create exceptional alignment in healthcare.’

Care provider contributors

Mount Sinai Health System

7,400+ **4.1 million**
Physicians Patients per year

New York City

- Established in 1852. An integrated healthcare system, including 38 research, educational and clinical institutes and top-ranked Icahn School of Medicine at Mount Sinai.
- Comprised of eight hospital campuses with over 400 practice locations.
- In 2013, Mount Sinai Medical Center integrated Continuum Health Partners to merge the hospital system with primary care services.

Interviewees



Niyum Gandhi,
Executive Vice President and
Chief Population Health Officer



Dr. Jeremy Boal,
M.D., Executive Vice President
and Chief Clinical Officer



Stephen Furia,
Senior Vice President, Population Health

Catalyst Health Network

570 **900,000**
Physicians Patients per year

Texas: Dallas-Fort Worth metroplex

- Established in 2014, one of only seven Clinically Integrated Networks in the country, with URAC full accreditation achieved in 2017.
- Comprised of and led exclusively by physicians, including 180 practice locations.

Interviewees



Dr. Chris Crow,
President



Jeff Lawrence,
Executive Director



Dr. Joe Lambert,
Medical Director

The leaders of four care provider organizations gave their time to participate in in-depth interviews for this report. They bring to life what Harvard has called a ‘3D model for value-based care.’ In the pages that follow, their voices are quoted directly and extensively, in order to capture their first-hand experiences and insights.

Ballad Health

1,400

Physicians

103,000

Patients per year

East North Tennessee & Southern West Virginia

- Established in 2018, through a merger of two major regional health systems, Wellmount and Mountain States Health Alliance.
- An integrated healthcare system covering 21 counties.

Interviewees



Marvin Eichorn,
Chief Operating Officer



Paula Claytore,
VP Managed Care



Dr. Shari K. Rajoo,
Medical Director of Population Health Services,
Medical Group

Rhode Island Primary Care Physician Corporation (RIPCPC)

162

Physicians

170,000

Patients per year

Rhode Island:

- An independent practice association, established in 1994.
- 78 practice sites as managers.
- Medicaid and Medicare combined 49 percent; Commercial 51 percent.

Interviewees



Noah Benedict,
Chief Operating Officer



Andrea Galgay,
Director of Accountable Care



Dr. Gregory Steinmetz,
Independent Physician

Why value-based care matters to care providers

‘We’re at a tipping point – we’re out of money in healthcare.’

When asked why their organization set off on the path toward VBC, all the care providers interviewed point first to the economic unsustainability and rising costs in the U.S. health system. They are stark in their expression of how the current cost crisis renews the urgency of getting this right as quickly as possible.

- “ We’re at a tipping point – we’re out of money in healthcare. The fact is that we’re paying too much for the outcomes that we get.
- “ The No.1 impetus is, unfortunately, how much healthcare costs. Period. People’s experience is that healthcare hasn’t got any better over the last 10 years and the costs have almost doubled.
- “ The healthcare system is in such a state of peril as it is, we have to do something. I feel we have to assist in that effort. What do we do if we don’t, at least, go down this path?

In this regard, their starting point is the same as the research conducted by Dr. Chien at Harvard. They have all been on this journey for years, even decades. They have experienced several iterations of contractual arrangements before what is now talked of as VBC, and the challenge of attempting to minimize costs while sustaining quality is not new to them. However, no one is talking only about the money; they are making two additional points. This is a strategic imperative, and they are motivated by a sense of mission.

Driven by a strategic imperative

Embarking on VBC, for them, is about taking a proactive, strategic approach to long-term structural pressures. Niyum Gandhi of Mount Sinai, sees it as his leadership responsibility:

“ In the fee-for-service world, there’s just going to be continued reimbursement compression. Versus, if we own the total cost of care problem: we take out the unnecessary organizational cost; we manage health better and keep people healthier; and we get some financial value from the new contracts. And that way we’re part of the solution, not part of the problem.

Rhode Island Primary, though very different from the large New York-based hospital system, came to a similar conclusion. Starting in the ‘90s with Pay for Performance and progressing through the Patient Centered Medical Home model to become an Accountable Care Organization today, they also took the view that, as a leadership team, instead of squeezing the old system harder, they needed to walk toward the challenge with a completely different frame of mind:

“ We saw the market evolving, and we saw many provider groups saying we want more dollars for fee-for-service. Our Board had the foresight, before many others did, to step back and say: ‘Alright, we know what the outcome needs to be, so let’s walk into these negotiations recognizing the payers have a bottom line, we want to do better financially and we want to improve outcomes. So how do we do that?’ When we sit across the table with a partner, everybody has to win. The patient has to win, the provider group has to win, the insurance company who is paying the bills needs to win.

Marvin Eichorn, who leads Ballad Health in Tennessee and has also been on this journey for some 20 years, echoes the sentiment that the drive toward VBC is necessitated by a mix of external pressure and internal commitment to fundamentally change how the system works:

“ This began to be mandated way back because of the unending rise in the cost of healthcare and, I guess, rightly so. So, today, part of it is imposed on us by outside entities; the Federal Government, managed care organizations, even employers. But part of it is a proactive effort on our part to do something that’s different. It’s something that makes sense to do. If you’re going to be successful, you’ve got to provide something that’s of value to people.

Motivated by the mission

For all these leaders, this journey is a continuation of strategic imperative and their commitment to their mission, as expressed by Dr. Crow, President of Catalyst Health Network:

“ It’s right there in our mission statement that we’re here to deliver long-term community value. You need to do some things that may not make money for you in the short run, in order to get to the long run. Because one thing you can count on is that you’re going to have a harder and harder time getting the full reward in the old way; that cannot be your business model. So, at some time you’re going to have to shift. Do you want to be forced to do it? In which case, you might not be the CEO anymore – or do you want to go ahead and choose it?

Crow grew up in a rural town in Texas where three family physicians provided all the care that was available, and where they also served on the City Council, the school and church boards. Seeing how they acted as ‘leaders who took care of people’s health but cared for the whole community as well’ inspired him to become a physician. Today, leading a network committed to VBC, he still draws directly on the lessons of his childhood:

“ We’re not only taking the role of physical healers, but also community leaders. My whole purpose now is how I work to help communities thrive. Health as a pillar of community. That means making sure that there’s a market for great quality care, at a reasonable price – which, ultimately, you’re going to call VBC.

Ballad’s Eichron shares Crow’s life-long commitment to strengthening the fabric of the community he works in – and his belief that VBC is a mechanism for achieving that:

“ I really believe that if Ballad Health can do this – and if we, as an industry, can do this – to the best of our ability, we can make a real difference in the health of people. To me, that’s fundamentally exciting. It gives us an opportunity to do some things that maybe almost no one in the country has had the opportunity to do before.

Joseph Lambert, Medical Director of Catalyst, presses home the point: in a system where he thinks ‘every interaction has become about the money,’ he talks about ‘turning the tables’ on how the problem is viewed:

“ We’re not just trying to save money. We’re trying to provide efficient, evidence-based care, and if we’re able to do that, we will save money. That means solving the problem from the other end of the equation. That is a better way of looking at it, in the end.

Even at Mount Sinai, a huge city-based health institution, the motivation was based in their core purpose set out over 150 years ago:

“ Our stakeholders are the community and, as a not-for-profit, that’s who we exist to serve. This is the right way for us to meet the needs of our community 50 years from now – so we should be starting on that journey now.



Value-based care needs to move beyond the financials

‘To deliver value-based care, you need to create a completely different type of organization.’

Harvard’s research opens up the question of whether the next frontier is VBC using what Dr. Chien calls a ‘3D model’ to guide program design – i.e.: reducing costs and improving quality combined with the third dimension of non-financial infrastructure supports.

The perspectives of the care providers participating in this study confirm that this third component of infrastructure supports is not only a desirable addition, but an essential enabler of their ability to deliver the changes that are needed. Their view is neatly summed up by Dr. Boal from Mount Sinai:



If you’re going to start to pay providers based on the size of the panel that they’re responsible for and the outcomes that those patients are achieving, then you need to support them with the resources, the workflow, the data and IT systems to be able to drive those outcomes.

Building a different type of organization

All these leaders stress the huge degree of change required inside their organizations in order to deliver on value-based contracts. They are having to reconstruct their entire operating model and systems in real-time. From the daily practice of their physicians to the shape of the workforce; from the use of data to the myriad measures applied to performance; from the expanding network of professional relationships to managing the increased burden of risk and investment. Everything changes – while continuing to deliver higher quality care consistently. As Niyum Gandhi puts it:

“ The actual contracts are the easy part; changing a contract takes a stroke of a pen. Changing the actual clinical delivery takes years.

It was this recognition that led Mount Sinai to take the critical step of creating a new unit entirely dedicated to delivering value-based care.



Niyum Gandhi,
Mount Sinai

“ It’s hard to deliver because it’s so completely different. To change to VBC is not as simple as just adding a bit more data and maybe adding another role to the team. It’s not possible to shift something that’s perfectly built for fee-for-service with just a few tweaks to become perfectly designed for value. In the traditional model, it’s more financially advantageous to see a complex patient for only 10 minutes and get them referred out to a specialist, so that the doctor can get on to the next patient. You’re focused on the 23 patients who are coming in today because that’s how you get paid; there’s no time to think about the 2,300 who you’re responsible for who aren’t coming in today. All of these things are built into the day-to-day operations. It’s two completely different outcomes you’re going after; it’s really two completely different types of organization.

Adopting a new organizational structure to drive Mount Sinai forward, leadership pulled contracting out from under finance where it would usually sit, pulled some of the clinical programs out of where they would normally sit, and built an integrated team for population health. According to Sinai’s Gandhi, that was meaningful and an important milestone.

“ One key breakthrough was the organizational structure we decided to adopt to drive us forward. We pulled contracting out from under finance where it would usually sit, pulled some of the clinical programs out of where they would normally sit, and built an integrated team for population health. That was meaningful and an important milestone.

We said, let’s suspend all of our assumptions about what primary care looked like in the past and let’s instead think about what a purpose-built model for VBC would be. Would we even have the same roles? And the answer is no. Almost every job description is completely different – as though cut from a wholly different cloth. The things we want people focused on, the tools that we give them, the way they structure their days needs to consider how to manage all 2,000 patients that they’re responsible for, whether or not that patient is coming in, whether or not they get paid for a face-to-face visit with that patient.

What stands out from Mount Sinai's experience of transforming the business model is the balancing act it requires, between committing to a different form of contract and constructing a new clinical delivery capability:

“ We view it as travelling along a diagonal: if we end up in the bottom right where we've changed the clinical model but not the contract, we would bankrupt ourselves – and if we ended up in the top left where we changed the contract but not the clinical model, we bankrupt ourselves. At the bottom left, optimizing fee-for-service, the math in there works. The upper right corner of VBC, where everything you do is optimized to deliver a clinical model for population health, that works. Every step in between is inevitably inefficient. Our job is to try and manage the balance as we go along that diagonal path.

This explanation highlights why the issue is not whether financial incentives work, but rather what else needs to be in place in addition to the financial incentives to support the change process going on inside the organization.

The financial incentives are necessary, but not sufficient

The focus of this study is on the non-financial and infrastructure elements of the journey to VBC, partly because – as identified by Harvard's research – this is an area much less fully explored. However, it is important to note that all the care providers interviewed confirm the power of the financial incentives. 'Getting the financial drivers right is foundational to success', as one voice said. The leaders of Ballad and Catalyst explain what it means to their ability to drive change:

“ If structured right, the financial incentives are by far the biggest thing that will achieve the value-based goals, and the absence of those incentives is by far the biggest detriment to it moving forward. It is not just about those financial incentives, but I do need to know first that I have got the ability to put in the resources we need to do all this.

“ I am contracted that if I save \$20 million, we get to keep half of it – so the financial incentive is there. Plus the care co-ordination fees give me the funds to create a system that the physicians can plug into. That way I have what I need to build something the physicians value, in terms of their time, their money, their reputation – and I am able to serve all those factors with this operating model.

For these organizations, financial 'incentives' are not simply a reward or a boost for having hit the goals. In effect, they represent the funding necessary to make the transformational organizational changes required to deliver in the value-based model.

Aligning the measures

Intrinsic to establishing the financial incentives are the metrics by which the organization's performance will be measured. They encapsulate the change in paradigm everyone is seeking to achieve. However, one of the pain-points that all the interviewees share is the proliferation of non-aligned measures involved in value-base arrangements.

Their experience underscores the importance of Harvard's recommendation on the need to better understand how to align these measures so as to reduce the significant drain on time and cost they represent for care provider organizations.

In part, the providers struggle with the sheer number of metrics they have to juggle. Eichron has counted up well over 500 measures that his teams at Ballad Health are required to track; zero infections, ED throughput, patient satisfaction and onwards. Faced with this ‘near impossible task’, he considers ‘sustainability’ the greatest performance challenge his organization now faces: how to sustain the gains made in one focus area, without ‘slipping back’ as they continually have to turn their attention to improving in new areas.

Beyond the challenge of quantity, however, is that each payer requires somewhat different measures. Shari Rajoo, a doctor herself, who leads on embedding new ways of operating into Ballad Health, is working to protect the physicians from the complexity this adds to delivery of care:

“ One of the most difficult things is that every payer wants things slightly differently and has a slightly different definition of their metrics. Diabetes control is a good example; one is looking for the proportion of your patients over nine percent hemoglobin, another for eight percent. A lot of work goes into satisfying that. But the last thing I want is for a physician on the front line to be wondering whether they have to do a different thing for this payer or that payer; that’s not what a front-line clinician should be concerned about.

This sentiment, echoed by Catalyst, shows up the dual challenge they all struggle with. The management burden of the vast quantity of inconsistent measures, is combined with a cultural gap between payer-provided data and its relevance to the day-to-day reality of the doctors:

“ Simplifying all the different data feeds that come in different file formats and definitions is definitely one of the most difficult aspects of VBC. One payer’s definition of re-admission is different from another payer’s definition of re-admission. We have to manage the discrepancies between each contract separately. And the measure is typically, for example, ERs per thousand or specialist visits per thousand. But physicians don’t think of things in the thousands; our lives are full of the individual patients we see every day. So, my job is to translate those measures into something that doctors can work with – and the problem is that costs a lot of money too.

Eichron identifies three essential elements to being successful under this pressure: the ability to ‘sustain’ improvements made, the ‘discipline’ to keep adjusting plans along the way, and access to ‘timely information’.

Data is a critical enabler

Universally, the care providers agree that payers can contribute a great deal more than financial incentives and, first and foremost, everyone cites data sharing.

Rhode Island’s Noah Benedict acknowledges the huge benefit added through both the claims and population data provided by the payers which gives his people access to information they did not have at their fingertips only a few years ago. One of Harvard’s findings is that the value of the data is more than the information itself; where data sharing exists it can ‘represent a shift in the relationship between payers and providers from a historically adversarial tone to a more collaborative one.’ Benedict’s reflections are evidence of exactly how that can happen:

“ It works because it creates transparency in how we operate together. The payers tell us exactly where they believe most of the waste is happening in our particular system. They look straight at me and tell me, for instance, where they see my ED rates are higher than others in the region and where the top opportunities are to improve that. That helps us; it’s data-driven. Then we can begin to have a conversation. And although I know that they want to save dollars, I’m comfortable because I can see how this concern is warranted: they can identify where the waste is; they can save dollars and we can benefit from launching the programs to tackle that. I know they’re not just trying not to pay claims. I give that data to our teams to validate their assumptions from the point of view of our organization, to confirm that this really should be a focus for us. And we sit back down at the table and agree on the steps we need to take.

In that picture, the shared data is the basis of a shared plan between Rhode Island and the payer. Meanwhile, for Steinmetz who faces Rhode Island’s physicians in particular, the data provides a persuasive external evidence-base that pinpoints ways of improving clinical practice:



Dr. Gregory Steinmetz,
RIPCCP

“ Doctors are very competitive, generally speaking. They take a lot of pride in their work and they want to feel they’re delivering care to the highest quality. So, when it comes to seeing our data in comparison to our peers, it’s a highly motivating factor; we want to be toward the top of the list. In our group, we have to believe we’re doing everything we could possibly do to limit emergency room visits, for example. But when you see data that shows that ER visits in this region are higher than elsewhere, that gets you to step back, to re-explore how we can do things a little better – and maybe not think complacently. It gives us that proper perspective.

Yet everyone expresses frustration with the way this works in practice. They all experience similar problems: consistency and timeliness. Working intensively on a plan that they will be measured and rewarded on, they are often not able to get the relevant data until possibly six months later. Shari Rajoo at Ballad explains the challenge:

“ Payers do supply data. But the issue that comes with it is that every payer delivers their data in a different way on a different timetable. The time lag is something we really struggle with. I might be looking at data about something that happened at the beginning of the year and now the year is almost over, so it’s really hard for me to effect a change in anything for the remainder of that year. And we have to work with them all individually because they all have different platforms and different requirements. That’s one of our biggest challenges.

Mount Sinai’s description of the situation gives a sense of the scale of the task in a large organization. Their VBC teams have instituted working groups with each of the health plans, meeting every two weeks or month, focused on quality metrics, on total cost of care reduction opportunities and on pharmacy because that is such a high cost area. Boal highlights how the data challenges described above by Ballad are similar to those for Mr. Sinai, and also how intertwined they are with the topic of metrics:

“ The information we get is very fragmented right now. Having access to all payer databases with timely information is very useful – but most of the payers tend to have proprietary approaches to performance programs and they all have slightly different variants on the metrics that they include. That creates a lot of chaos on the provider’s side because it’s extremely hard to unify around a set of measures that we can share with our physicians, office staff and hospital staff, so they know what they need to focus on to do better for their patients. So we’ve invested an extraordinary amount of money and energy in developing our own all claims database to try and make it easier.

Managing multiple metrics and multiple payers has led Mount Sinai to become more explicit in their value-based contracts about data, in order to be comfortable that they can deliver on the metrics they will be held accountable for:

“ It’s shown us we need to get agreements into our contracts around timeliness of reporting and what data we’re actually going to get. What we can’t get agreement on across all the payers is one standard unified set of measures because they’re not ready to unify at this point. They view those as market differentiators. That’s why we’ve learned to write a lot into the contracts about having access to unadjudicated claims information.

The experiences shared by these care providers tell us that not only can payer-provided data be considered an additional incentive to help VBC become more effective, but that it needs to be considered an essential factor underpinning care providers’ ability to deliver. From the perspective of care providers, the next frontier in VBC requires seeing timely, consistent data as an intrinsic part of value-based arrangements not as an option on top of financial incentives.

Care support is a critical extension of physician resources

Another main category of infrastructure supports identified by Harvard where payers have the potential to make a considerable contribution is in enhancing care management and other care extension and coordination roles. The care providers participating in this study all agree with that premise. As Shari Rajoo describes it, this is an area which has proven to make a real difference in the interaction between physicians and patients at Ballad Health:

“ In this journey, what has really facilitated the difference in the delivery of care here today versus five years ago are the additional team members we’ve been able to put in place. We now have teams who can assist the physicians with concerns they don’t have the time or means to solve in the office. People who can help the patient with those things or direct them to other resources. So that person is getting cared for – but not everything is resting on the physician’s shoulders.

So, the challenging issues arise not with whether to augment and strengthen these care support roles, but with how that capacity is delivered: who does it and how is it paid for. The main area of contention is who should fulfill the role. The common view, illustrated here by Mount Sinai, is that these roles represent an extension in care and should be delivered by care providers:

“ We have two sets of people trying to do it now. In my experience, it has not been successful for the payer to do this work. I think medical care should be left with the provider and utilization review can happen with the payer.

“ In general, our belief is, as we move more and more toward risk on any individual contract or with any individual payer, we think we could do a better job of managing the care management needs because we’re closer to the patient, rather than leaving that with the insurer.

Mount Sinai adds however that there are times when, in their experience, the payer is ‘a better fit’ for delivering care co-ordination, citing in particular specialty care such as hip or knee joint surgery. At present, a challenge for all providers contractually is whether a per patient fee applies, making the total cost of care figure more expensive, versus providing the resources directly to the care provider, allowing the organization to employ those individuals as part of their overall operating expenses.



How provider-payer relationships are being reset

‘We’re chipping away at years of ossified relationships and reframing the conversation.’

Reflecting on the nature of the working relationship between care providers and payers, the baseline that everyone is starting from is clear:

“ We’re chipping away at years and years of ossified relationships that are built on an adversarial approach and reframing of the conversation – and that happens at the individual person level.

In the leadership interviews, the way people describe how they transform this historic divide was startlingly fresh and all to do with human interaction:

“ This has been one of the most interesting and exciting parts of the work. It takes progressive leadership on both sides to make this happen. It’s not enough for the payers to say we’d love to try some new things, the providers need to do that as well. It’s not enough for the providers to do it, the payers have to do that as well. That’s really important: to look for common ground. And there’s a ton of common ground, if you’re willing to look for it.

Listening to these care providers, it is clear how the opportunity to establish new ways of operating with payers, aligned around the same goals, has proven to be an area of real creativity and potential.

Sitting down together

At Mount Sinai, it started at the top. ‘One important step was building a different type of relationship with the health plans at the most senior level that we could – with folks that were not the normal head of network at health plans’, explains Niyum Gandhi:

“ The six of us sat down, their team and ours, and talked for 90 minutes about where they are going and where Mount Sinai is going. There was no negotiation there. It was relationship building. And on the heels of that, they reached out and invited us to spend time with a set of their executive leadership. I brought my team that does a lot of the health plan relationship and some new parts of my team that are focused on finding win-win opportunities. And we spent a full day with them. Now we have monthly check-ins just to see where things are in our organizational relationship. So, we have that to rely on as we work through the difficult work.

That has become common practice across all their health plan relationships. Jeremy Boal, Mount Sinai’s clinical lead on VBC, is focused on determining where the mutual benefit lies:



Dr. Jeremy Boal,
Mount Sinai

“ We had to come up with a new way of doing business where maybe none of the parties get exactly what they’re looking for, but it gives us an opportunity to start on different kind of work together. Sitting down eye-to-eye and working out the details, trying some things and being willing to not have it all be our way or their way is, I think, how you build trust. Then to have a few successes, to continue the dialogue and try a few new things, a few more things.

This step-by-step, progressive approach has proven to be key to building delivery capacity while taking on greater risk in the contracts. Boal stresses the importance of having people from their team involved who continually consider the financial implications of the new approaches being developed.

‘Having experts in the room who we feel confident are really thoughtful about how not to break the bank as we do the work,’ as he puts it:

“ You have to recognize that we’re in this for the long haul. It’s not all about getting the biggest win on the first contract. It’s about creating a series of building blocks so that we learn together and evolve together: we try a few things that are not too risky for either side out of the gate and we go from there and try a few new things.

The power of ‘sitting down together’ to come up with a new way of working together was a recurring theme in the interviews. In Rhode Island, because it is a small state, the Healthcare Commissioner has played a catalytic role in ‘getting all the parties at the table together’, as Andrea Galgay explains. She believes it helped payers understand more clearly the real importance of primary care in the new delivery model:

“ Often, we have multiple payers and multiple provider groups in the room when we are discussing new types of activities. There’s always going to be a level of tension between payers and providers, but we’re all marching along the same path. So, the first thing is to build trust and that means taking a leap of faith to try some of these new things – understanding that we might not perform at 100 percent at first, but we’re going to learn together and then improve our programs accordingly. It’s very important that providers like us are willing to do that.

The readiness to work in this open way is, in itself, an act of building trust. It creates shared buy-in to the solutions:

“ One thing that successful payers are doing now is bringing together people who all have a part of the solution. Too often, historically, health plans have thought, ‘We’re the organizer of the supply chain here; we know best, so here’s what the solution is; we want you to buy it’. But, of course, when that happens everybody else abdicates their responsibility to the solution. Wherever we’ve seen improvements in value, it’s almost always when all the parties get together at the beginning of a process – saying, ‘Forget what we all do today for a second, and let’s all play a role in creating the solution.’

No one is claiming that this is easy or quick. All of them cite the need for transparency, meaning shared, data-led, evidence-based decision-making and monitoring of progress. They also refer often to transparency of motives; the need for everyone to be clear what their goals are in the shared enterprise – ‘everything out on the table’. However, if those criteria are in place, they are all confident that it is possible to create win-win relationships with positive benefits for patients.

Collaborative design

The success stories that these care providers shared are born out of this profoundly new way of working. They are created in a spirit of what Stephen Furia at Mount Sinai calls ‘collaborative design’ and, typically, they are focused, new initiatives that create the opportunity to design a solution from scratch:

“ There’s a lot of collaborative design going on. That gives us a chance to build a new vessel for how we deliver VBC in our organization. There are places where it’s not a zero-sum game; where if we think together with payers about reasonable quality metrics, we’ll be focused on the right thing. Where if we think about the data we need to share back and forth, we’ll be focused on the right thing.

The instances where Mount Sinai has had particular success with collaborative design are worksite programs and specialty care. (See case studies pages 44 and 45). What these case studies have in common is that they are innovative projects, focused on a small enough scale to allow everyone involved to design a new way of operating together and then to deliver that project jointly. The mutual wins and measurable results have led Mount Sinai to replicate this approach in other work site locations in other sectors and across other forms of specialty care, including hip, bariatric and cardiac surgery.

The win for the patient was measured in health outcomes and experience, but also in affordability. In a situation where the typical family today may be taking home around \$50,000 a year in income on average and facing deductibles on their healthcare of \$1,500 on average, Dr. Boal’s team are pleased with being able to deliver this new model often with zero out of pocket for the surgical procedures for the patient.

These success stories serve as a source of inspiration to those on the long journey toward VBC. As Mount Sinai’s Stephen Furia says:

“ You get discouraged when you think about the scale of the problem of getting hundreds of thousands of parties to change. But you get encouraged when you work together on a smaller scale and you can really see that this is possible; this really can work.

At a personal level for the individuals involved, the opportunity to play an active part in designing a new care model for the future is energizing and meaningful. Furia likes working on innovations that may be deployed with all his patients a few years from now:

“ For these new offerings that we put out there, we have the freedom to start to rethink everything. To sit together and say, ‘What if we didn’t have to live by the current benefits structure, the current reimbursement roles, the current care delivery models? What if we could create something that is purpose-built to deliver value? What would that look like? It gives us a once in a lifetime opportunity to create exceptional alignment in healthcare.’

Shaping consumer behavior in health

Product design is another contribution payers can bring to table, in the view of the Rhode Island team. Based in a state where there is a significant challenge with consumers self-referring for specialty visits and high ER utilization, they are acutely aware of how the cost of care can ramp up without a commensurate improvement in health.

These leaders all expressed concern about how to shift consumer behavior. They fear that without tackling that, the efforts of the professionals throughout the system are doomed to fail. In that context, they believe that payers have an important contribution to make, as Rhode Island’s Noah Benedict outlines:



“ The way payers can design their products could shape patient behavior in a way I don’t believe we, as care providers, are capable of with just education or training. If their product is telling consumers, for example, that a visit to the Emergency Department without checking in with your doctor will cost you a lot more, it might give people pause before incurring that charge. Money shouldn’t be the only factor here, of course, but it is a very powerful one.

Noah Benedict,
RIPCPC

Benedict sees the next step as enhancing the collaboration with insurance companies and employer groups to co-design insurance products that drive consumer behavior to ensure improved outcomes and drive down costs.

Case study

A worksite health center built on a commitment to primary care

The problem

Mount Sinai partnered with a labor union in Atlantic City to help them figure out how to improve the health and productivity of their union workforce and, at the same time, crack the nut on the affordability crisis.

The union had decided to invest in a 10,000 square foot health center and hire a third party to develop and deliver an exemplary version of the primary care model. Right from the outset, everyone agreed that fee-for-service should play no part in the vision for the center.



We began with what we think is the important thing for the future: we sat down with them and their health plan administrative partner and we designed collaboratively the model we thought would produce the greatest value.

The solution

Together they developed a financial structure where Mount Sinai was incentivized to spend the necessary amount of time with patients to try to help them on a course towards prevention. They articulated a shared mantra: 'Refer less, refer smart.'

A few key decisions were critical to success:

- Ensuring patients consume healthcare within the center, as much as possible – and only referring out to a specialist when really necessary.
- Only referring out to specialists in the community who practice evidence-based medicine.
- Operating an open-access schedule, expanding the hours of the health center.
- Conducting a significant community engagement program, including reaching out to patients with chronic illness with a number of service enhancements made possible through the investment in primary care.

In addition, since so much of a poor patient experience comes from the lack of a strong connection between the roles of the care provider and the payer, the center offers a level of navigation services that is not typical. A person at the front-desk from the care provider team is able to answer patient questions about health plan benefits – and vice-versa: there is a direct transfer from the center to a dedicated account rep at the health plan offices.

The results

Mount Sinai improved their business from the population health standpoint, improved the health plan's stickiness with the employer and provided better service to both the employer and the employees.

The new, co-created model delivered results in the first year:

- The volume of visits to the Emergency Department reduced by around a third, flowing through into cost savings.
- The center achieved a Net Promoter score of 86.



We took it back to some basic questions. What if we didn't have to play by the existing rules? What if we really invested in primary care to make it deliver what we think it should, what would that look like?

Case study

Transforming the delivery of specialty care

The problem

Mount Sinai initiated a bundled payment program for knee replacements. They identified two priority challenges to focus on in specialty care. First, waste across the system. Second, the difficulty of persuading consumers to engage more effectively in their recovery – leading to multiple, non-necessary visits to the emergency room.

All the parties involved sat down together to map out a program to transform the outcome. They identified a fixed price that everybody could be comfortable with – and would save the customer money.



We started to build out processes in front of the surgery itself – including asking, ‘Should this surgery even be done?’ You have to define the rationale for how you will deliver each process step because that’s where the waste is.

The solution

Mount Sinai was incentivized to consider not only the intervention of the surgery itself, but the spend along the entire continuum of the treatment. That led them to change how they approached the process end-to-end:

A few key decisions were critical to success:

- Preparing people for the surgery, a Joint School was set up to explain to patients what the journey would be like.
- Interviewing the patients in their home to assess practical risks, such as the potential for a fall.
- Providing services that previously would not have been part of the service, including free rides to follow-up appointments.



Appointing a navigator to guide patients through the entire journey, staying close while they are in the hospital, reviewing the care plan for their return home and acting as a resource when they need to answers to questions – eliminate the need to go to the emergency room to get attention.

The results

In each of the first two years, the results showed an improvement in both the denominator and numerator of value:



It saved the customer \$800,000.



It achieved 91 percent patient satisfaction, because people recognized that they were getting more than a surgery; the outcome was improved mobility and reduced pain.



This is one of the greatest win-win-wins that I’ve seen in my 20-year healthcare career. The patient got a win, the customer got a win, the payer got a win and, as the provider, we also got a win. We got more business, not in the old-fashioned way by hiring more physicians – but because we’ve created value and earned more business from a customer who likes the value that’s been created.



The secret of success:
the commitment of leadership
and physician alignment

‘Physician leadership
has to be a cornerstone
of the organization.’

Each one of the participating care providers homed in on the leadership of commitment as essential to success:

- “ No.1: it’s got to be something the organization’s committed to all the way to the top – including the Board of Directors that we’re ultimately accountable to. It all starts at the top.
- “ It all starts with the vision and leadership. Because, if you’re a health system and your leadership is looking just at the next two years, you’d keep fee-for-service. If you’re a good leader, you have to look at it and say, ‘In the middle of the next decade – we’re all going to have to start living on a budget’. And you could get discouraged because you realize you’re going to have to change so much – so you don’t respond. Or, you can start on it today and say, ‘I’m going to have a deliberate multi-year plan such that when we get to the middle of the ‘20s, we know how to do this’.

Staying power

The significance of leadership commitment is explained not only in terms of setting the strategic vision, but of staying power. Stephen Furia, whose role at Mount Sinai is to operationalize VBC, knew he had the determination of leadership behind him:

“ Any time I found that I was running into serious barriers, he would say, ‘Whether we do it over six months or we do it over two years, we have to move in this direction’. So, as an example, the conversation of changing how we pay several hundred primary care physicians is pretty meaningful and, of course, there were bound to be people who didn’t want to change it. But he’s committed to this new organization, so he just states again that this is the direction we’re going in and continues to push for it.

Furia’s colleague, Jeremy Boal, explains that even for an organization the size of Mount Sinai, every dollar spent on VBC is a dollar not spent on something else:

“ It takes a significant amount of internal fortitude and commitment to see this through. Because it’s very easy to get put off by the types of investments that are required – but, on the other hand, I do think that under capitalizing this kind of transformation is a real risk for organizations.

Rhode Island Primary’s experience has been similar, requiring resilience in leadership:

“ The CEO had to stand strong and say: ‘We are in this together, we are going to help each other and this is the way it’s going to be.’ Just maintaining that culture.

The challenges of change range from reshaping the way people are paid, committing to high levels of investment, persuading experienced professionals to learn new ways of operating – and even asking the best performing players to share their success in support of their lesser performing colleagues. They all operate on the basis that they are going to meet resistance along the way and, as Crow from Catalyst Health puts it:

“ You have to be persistent in your messaging. And consistent in your messaging. And you have to be passionate. Make sure people see activities that show you are serious. This is not a passing fancy.

Physician leadership

At Rhode Island Primary, with 150 doctors in the network, Noah Benedict identifies physician leadership as the critical success factor for his organization. They have set up committees focused on quality, on utilization, and even committees specific to pharmacy and behavioral health, all physician-led:

“ True physician leadership has to be a cornerstone of an organization like ours in the collaboration you have with payers on value-based reimbursement. I truly believe that. When you have one practicing physician explaining to another physician why these changes are necessary, how it improves patient care and perhaps improves the financial aspects of the practice as well, that rings true to people.

The Rhode Island Primary team also highlighted another success factor: the sharing of leadership responsibility. Dr. Gregory Steinmetz, who is credited by his colleagues as being a lynchpin of the transformation, has a structure around him that helps him share the load and amplify the effectiveness of the change program:

“ There are at least 20 of us who are of one mind when it comes to how we proceed with this vision. We share that vision. So, when issues arise there are many of us able to speak with the doctors who may have concerns. They can explain how the issues have been handled by the Board – with physicians at the table – how those concerns have been debated in an open forum and how the decisions were made. This structure really opens it all up. We’re not having to go person to person to convince them this is the direction we should move.

So, at Rhode Island Primary, beyond the core of 20 or so people, there are 40 more participating at the committee level, whose role is not simply to rubber-stamp, but to develop protocols that are recommended to the Board of Directors that are then adopted throughout the organization. Steinmetz describes is how it is designed to embrace more people as the new model takes root:

“ Everyone feels part of the change that’s happening; they feel part of the progress. And if you want to participate, there is a place for you.

Harvard’s research found that, while a large proportion of provider groups today participate in at least one VBC arrangement, these still represent a minority of the total reimbursements, therefore making it only rational for organizations to be unwilling to make changes that are incompatible with the historic fee-for-service model. Dr. Crow recognizes that tension at Catalyst Health, saying:

“ It’s really hard in a health system where the main way of making money is still butts and beds to align activities so that they show a different kind of value – and it creates cynicism.

Furia at Mount Sinai – which has shifted fast from around 20 percent value-based arrangements in 2014 to 80 percent today – describes handling this dichotomy as:

“ It’s somewhat schizophrenic but absolutely necessary. We have pockets of physicians who are incredibly happy. Many of those started out as skeptics but it’s working for them. They’re comfortable with their reimbursement and they’re getting more help in getting the work done. On the other hand, we have a lot of physicians who haven’t had a lot of exposure to this yet and they’re justifiably nervous still.

Their experiences reinforce Harvard’s observation that increasing the share of provider group reimbursement tied to value-based arrangements may, in itself, act as a catalyst to delivering greater impact on care delivery – and that there is an opportunity to explore further the potential for value-based incentives to be attached to individual physician performance, rather than only to the organizations.

Winning hearts and minds

The teams at the helm of these transformation programs are conscious that it is absolutely essential to take people in their organization with them on the journey. Niyum Gandhi is very clear this is a top priority, ‘Because we can’t do this as just a few executives working on it; we need the army of the entire organization moving in this direction.’ That is why he spends 30 percent of his time winning hearts and minds of Mount Sinai’s 40,000 strong workforce:

“ When they get over their initial skepticism of what this is, they’re very receptive. At first, they’re asking: is this just a way to squeeze us more? And the answer is: no, actually, we can give you more resources so you can deliver better healthcare. So you can spend time with your patients in a different sort of way. In the hospitals, talking to the people working in the emergency room, they’re used to their workflow being focused on just admitting patients and hoping the hospital can figure it out tomorrow and all the costs associated with that. So if we can decompress their days a little, if we can give them more resources, if we can give them more time to get patients safely transitioned home, they’re receptive.

They all agree how important it is to recognize the validity of the concerns expressed by people in the organization. This is risky and, in many ways, it is counter-intuitive, as Ballard’s Marvin Eichorn explains:



Marvin Eichorn,
Ballard Health

“ You have to do something that you wouldn’t normally ever do as a business – and that’s to take proactive steps that ultimately result in you having less volume. If I get a report from our hospital that we’ve got three percent fewer admissions than last year, that’s now a good thing. I shouldn’t feel positive if it had gone up because it means our efforts to keep people out of the hospital aren’t being successful. That’s very difficult to do; very difficult.

Success stories of VBC in action are without fail their greatest asset in building confidence among their colleagues, the case study from Mount Sinai cited in the previous section, specialty care. ‘There will be a lot of moments where people are going to want to go backwards or say this isn’t working, or it’s not worth the investment. And just being committed to moving slowly and inexorably in this direction is the only way,’ reflects Gandhi.

Dr. Crow goes back to the original impetus for setting off on the journey in the first place, the synthesis between the strategic imperative to respond to rising costs for everyone involved, including the patients, and the sense of mission that people bring with them into healthcare:



Dr. Chris Crow,
Catalyst Health Network

“ If you understand the basic problem which so many of our patients face that their healthcare cost has doubled; it’s eating into their income and now they have to make trade-offs about transportation, food, clothing and education. Who wouldn’t want to be on the winning team in fixing that? Who doesn’t want to be part of a solution that is better for them and makes you feel good?

