A strategy for building a value-based care program

How data can help you shift to value from fee-for-service payment

What is value-based care?

Value-based care is any structure where health care is reimbursed based on clinical or financial outcomes. In a value-based care program, the core measurement of care is focused on the overall health of a patient or a patient population (rather than individual units of care). A core tenet of value-based care is that it enables **efficient** care—safe, quality care that is delivered in a timely manner.

Value-based care is the intersection of cost and quality.

Getting to value-based care.

For a payer, the move from fee-for-service reimbursement to value-based payment can be a painstaking process—and not just for you, but also for the healthcare providers in your networks. But, with the right data and a proven strategy, it doesn't have to be. The transition to value-based care can be manageable—and ultimately successful.

This eGuide outlines a strategy that empowers both public and private payers to use data for measuring and improving the value of health care.

Set a solid data foundation

Whether you want to build programs for population health management or accountable care, experiment with new payment models, or forge community partnerships to improve market competitiveness, a solid data foundation is the place to start. With the right data, you can assess the current situation, identify opportunities to improve performance, design an appropriate program and track your progress.

Creating a solid data foundation involves acquiring, aggregating and refining disparate information to produce the most relevant dataset. Acquiring and aggregating data may sound straightforward, especially for health systems eager to mine the data in their EHR and data warehouses.

But the reality is it's a complex process that must be approached with intense care and skill—your dataset will guide and support you in every effort to increase value. If data integrity is not high, the result can be poor patient health outcomes and sunk costs.

With a solid data foundation, you are prepared to embark on the four tactics of a value-based care program: reduce variation, introduce value, improve total cost of care and enable sustainability.

To effectively use multiple sources of data, it's important that you first:

- Secure appropriate information from internal and external sources (e.g., patient longitudinal records, claims data, health risk assessments, lab data, and HIE and public health data)
- Create an infrastructure to house it
- Check the integrity of the data
- Cleanse the data and resolve discrepancies, applying business rules to make it fit for use
- Harmonize the data by matching patient records
- Attribute patients to primary care physicians
- Apply risk adjustment
- Test for accuracy and completeness

Reduce variation

Next to the high price of health care in the U.S., *variation* in price for the same procedure from one physician or facility to the next is a huge concern. By reducing variation in price or payment, you can better assess quality, and therefore increase the value of health care.

One way to do this is to measure services by patient using a severity and risk-adjusted methodology, such as the **3M™ All Patient Refined DRG Classification System** (inpatient) or the **3M™ Enhanced Ambulatory Patient Grouping (EAPG) System** (outpatient). When you weight payment for a service according to a risk-adjusted DRG, you justify increases in price by the risk of a patient having complications, needing longer recovery or requiring more care. It normalizes the price of services across a system or network.

A risk-adjusted DRG also lets you compare performance between facilities and physicians. When the average outcomes for similar patients differ widely among a group of providers, you can identify both good and poor performance. You can then design incentives to help poor performers improve and share the risk-adjusted data to help them understand how to change their delivery of care.

Variation in care also needs to be addressed. Why do some patients have poorer outcomes than others? Why do some patients receive optimal treatment while others don't? Knowing the disparities in treatment and outcomes and tracking them by patient and physician are the first steps to optimizing treatment, reducing waste and improving patient health.

Of the many metrics available, those focused on value-based payment:

1. Are objective, derived from standardized data sets and risk-adjusted

2. Allow for continuous measurement, even as payment models and clinical practice changes

3. Represent outcomes—the results of care—not the processes of care delivery

4. Link clinical outcomes with costs

5. Can be correlated with patient experience

6. Help clinicians and managers understand where and how to improve quality

Introduce value

Value-based payment changes the basic metric of care from a visit (unit of care) to the patient (or patient population). This concept considers how all aspects of care affect a single patient, rather than looking at each diagnosis or encounter individually. In theory, this seems like a simpler way to measure care. In practice, it has spawned a complex universe of new measures.

Although contracts and regulations may require your organization to track and report redundant or weak measures, you don't have to use them to manage your own internal programs. Choose a limited number of key performance indicators suitable for your project.

Since **value equals quality divided by cost**, the trick to measuring healthcare value is in measuring discrete, relevant aspects of quality against the total cost of providing care.

This can be done by selecting a core set of metrics that represent critical aspects of quality, such as health or functional status, changes in health risk, mortality, access to preventative care, continuity of care, chronic and follow-up visits, readmission and complication rates, imaging and ED utilization rates, and composite measures.

Measure what matters

3M has developed several methodologies to help you assess the value of care delivered. And we've operationalized these measures for over 200 payers and health data organizations, helping them implement payment programs that lead to better patient care at lower costs.

3M quality metrics track value		
Metric	**What it does**	**How it impacts value**
3M™ Potentially Preventable Readmissions (PPRs)	Identifies 70+ types of readmissions for all payers and patients	The 3M "preventables" identify healthcare "waste"—such as overtreatment, complications, never events, unnecessary or redundant testing, and services that could be provided in a more appropriate setting. They show you what could be avoided with different or timely interventions.
3M™ Potentially Preventable Complications (PPCs)	Identifies 60+ types of complications from hospital care	
3M™ Population-focused Preventables	Identifies avoidable ancillary services, initial hospitalizations, and emergency department (ED) visits	
3M™ Clinical Risk Groups (CRGs)	Classifies patients into risk-adjusted groups by clinical characteristics, severity and burden of illness	3M CRGs provide insight into a patient's health status, clinical risk and expected utilization—creating a way to link the clinical and financial aspects of care.
3M℠ Value Index Score (VIS)	Assesses 16 aspects of primary care in a single composite score	3M VIS measures how well a primary care physician cares for patients, regardless of their health status, and can be linked to value-based payment.

Improve total cost of care

Cost in health care proves nearly as difficult to measure as quality. The most accessible cost metrics are Medicare (or other payer) rates and hospital charges, but they don't represent the full costs including testing, medications, anesthesia and follow-up visits.

What you really need to measure is the **total cost of care:** the paid claims and co-payments across *all* providers and *all* care delivery settings associated with an individual patient.

This information is as important to hospitals and physicians as it is to payers and should be shared among all stakeholders. Providers need to understand the total cost of care for the patients attributed to them—even for services provided outside their own facility or practice. This includes costs for inpatient, outpatient, emergency department, laboratory, radiology and pharmacy services.

By understanding where and how costs are incurred, providers can spot opportunities to shift care to more appropriate settings. Their ability to manage total cost of care is critical to remaining profitable under new payment models and competitive within their market.

Total cost of care is the sum of all medical expenditures for a patient or group of individuals. It's the total dollar cost of all services in the delivery of care, including what is paid by the insurers plus what's paid by the patient.

Enable sustainability

Quality improvement projects often fail after they meet their initial goals and managers shift attention to other, newer projects. That's why every blueprint for value-based health care needs a solid framework for sustainability, including the ability to scale a pilot project across an entire network or health plan.

Long-term success requires ongoing attention to the following tasks:

Attribute patients to primary care physicians (PCPs)

To accurately attribute a patient to a PCP, an organization must integrate claims and eligibility data, define precise parameters, scrub and merge the data using a master patient index, and create a process to reconcile redundancies and gaps. The result is a single record for each patient and a distinct patient population for each PCP.

Define episodes of care

Chronic and complex patients don't usually experience one disease at a time. Their health is the result of multiple conditions, each affecting the other. It is important to think of episodes in terms of the whole patient, all conditions together, in order to properly manage care and correctly anticipate the total cost of care.

Provide transparency

Transparency in health care is more than a quality snapshot, a physician portal or average prices posted on a website. It is a philosophy in which all stakeholders—consumers, physicians, hospitals and payers—have access to the right information at the right time and in the right form. A truly transparent program responds completely to stakeholders' questions and decisions about cost, quality, risks and consequences.

Set metrics and benchmarks

It's true that what gets measured gets improved. But a lot of projects flounder as the result of choosing the wrong metrics and failing to groom an accurate, robust data set before starting the analysis. Up-to-date metrics also give you consistent feedback, informing you of any mid-course adjustments you should make to reach your cost and quality goals.

Align incentives

Clinicians are driven by a passion to improve the lives of patients, not by an interest in checklists and spreadsheets. The way they are evaluated and compensated needs to be directly related to clinical (health) outcomes.

Health information and payment. Simplified.

At 3M, we manage health data and program design so you can manage what's most important—the health of your members. Our solutions are designed to help payers, managed care organizations and provider-owned health plans change fragmented, encounter-based health care into integrated, value-based systems, such as accountable care organizations (ACOs) and population health management programs.

3M populations and payment solutions prepare organizations for population health, payment transformation, risk assessment and collaboration. The portfolio includes the following solutions for value-based health care:

3M℠ APCD Solution Suite provides data warehousing, analytic tools and strategic consulting for organizations that want to create a multi-payer database.

From statewide, mature accountable care programs to regional, pioneering quality programs, 3M has helped payer organizations adopt value-based care models for over a decade.

We have helped our clients:

- Save $100,266,661 in medical costs[1]
- Improve ACO quality scores by 35%[2]
- Reduce hospital-acquired conditions by 15%[3]
- Eliminate unnecessary readmissions by 19%[4]

Ready to start achieving your cost and quality goals?

Call 800-367-2447 to speak with a 3M representative, who can draw on deep experience with value-based care and population health management.

3M™ Healthcare Transformation Suite helps healthcare payers implement and manage value-based care and population health programs collaboratively with providers. The suite is a collection of consulting services and analytics tools, such as performance dashboards, predictive models, care management reports, analytics platforms and learning resources, designed to move payers and providers from volume- to value-based models of care.

3M℠ Primary Care Connections Suite* combines an online application with consulting services to give primary care providers the data insights and support tools they need to execute on population health management. It helps PCPs organize and prioritize the actions needed to deliver optimal care while achieving the financial and quality goals of a value-based care program.

3M supports better health care for 53 million lives[5]

*3M℠ Primary Care Connections Suite is currently in beta release and is scheduled for general release in the first quarter of 2016.

References

[1] "Response to the Joint Budget Committee's Request for Information #4 regarding the Accountable Care Collaborative," Colorado Department of Health Care Policy and Financing, published November 2014, available as of 09/15 at http://1.usa.gov/1OyoICs

[2] "Case study: Wheaton Franciscan Healthcare-Iowa and Wellmark® Blue Cross® and Blue Shield® of Iowa," 3M Health Information Systems, published June 2015, available as of 09/15 at http://bit.ly/1G73aVD

[3] "Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions," *HealthAffairs*, December 2012, available as of 09/15 at http://bit.ly/1gUAOXL

[4] "RARE Campaign Prevents 7,975 Avoidable Readmissions," RARE Campaign website, published May 2014, available as of 09/15 at http://bit.ly/1YFrZn5

[5] Represents the number of unique individuals for which 3M has processed claims data.

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3Mhis.com**.

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