

SPECIAL ISSUE

THE **Value** PROPOSITION



WHY NOT

## *An innovative approach to implementing the value-based care transformation*

**A**MGA's 2022 Annual Conference in Las Vegas offered a diverse itinerary with several standout sessions, including "Implementing the Value-Based Care Transformation: An Innovative Approach." This session was led by Karyn Springer, MD, senior medical director, GME, Utah Medical Group Board Chair, Intermountain Healthcare; Will Daines, MD, medical director clinical operations, Castell; and Dave Henriksen, vice president clinical operations, Castell. Their presentation offered a detailed narrative regarding how Intermountain Healthcare established Castell, a wholly owned subsidiary, to be a proving ground for their population health and value-based care transformation efforts.

Opening the session, Springer acknowledged a number of basic truths that the greater healthcare community has come to accept: that healthcare has become increasingly unaffordable; that mergers and acquisitions are becoming commonplace; and that new, nontraditional competitors are vying for the attention

of a new consumer-class patient structure. Continuing to intertwine and coexist through these paradigm-shifting changes are the fee-for-service and value-based care models, which are regularly at odds with one another.

Springer related, "A lot of times, you hear this national view: It's fee-for-service or value, right? It's fee-for-service: bad. Value: good. Fee-for-service is just cranking, and value is all quality. Well, the thing is, it's actually together, right? It's not about bad and good. It's about trying to find the right incentives and how to align them to get the right outcomes. More specifically, it's about getting the right care to the right person at the right time. And that requires a huge change in our status quo."

Looking for a way to stay relevant in the future as an organization, Intermountain needed to re-examine its care finances, integrating value into its practices while acknowledging that fee-for-service couldn't simply be eliminated from the care equation.

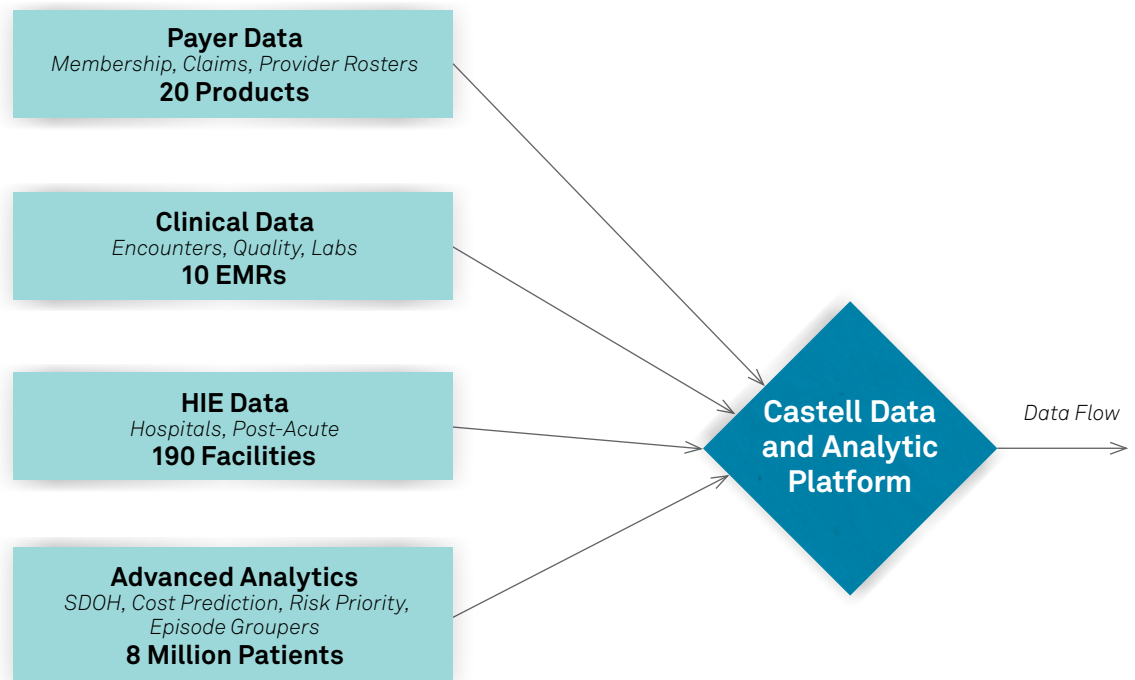
# ***BOTH?***

■ **Featuring Karyn Springer, MD, Will Daines, MD, and Dave Henriksen, MHA**



Figure 1

## Data Analytics and Care Traffic Control



### Reimagined Primary Care

Intermountain quickly took steps to establish a pilot to test its value-based capabilities. Called Reimagined Primary Care, the program targeted financially at-risk patients, employed chronic disease management and prevention tactics, as well as clinical risk stratification and resource utilization, focused on consumer-centric transparency, and utilized data-supported tools to identify risk and improve patient health.

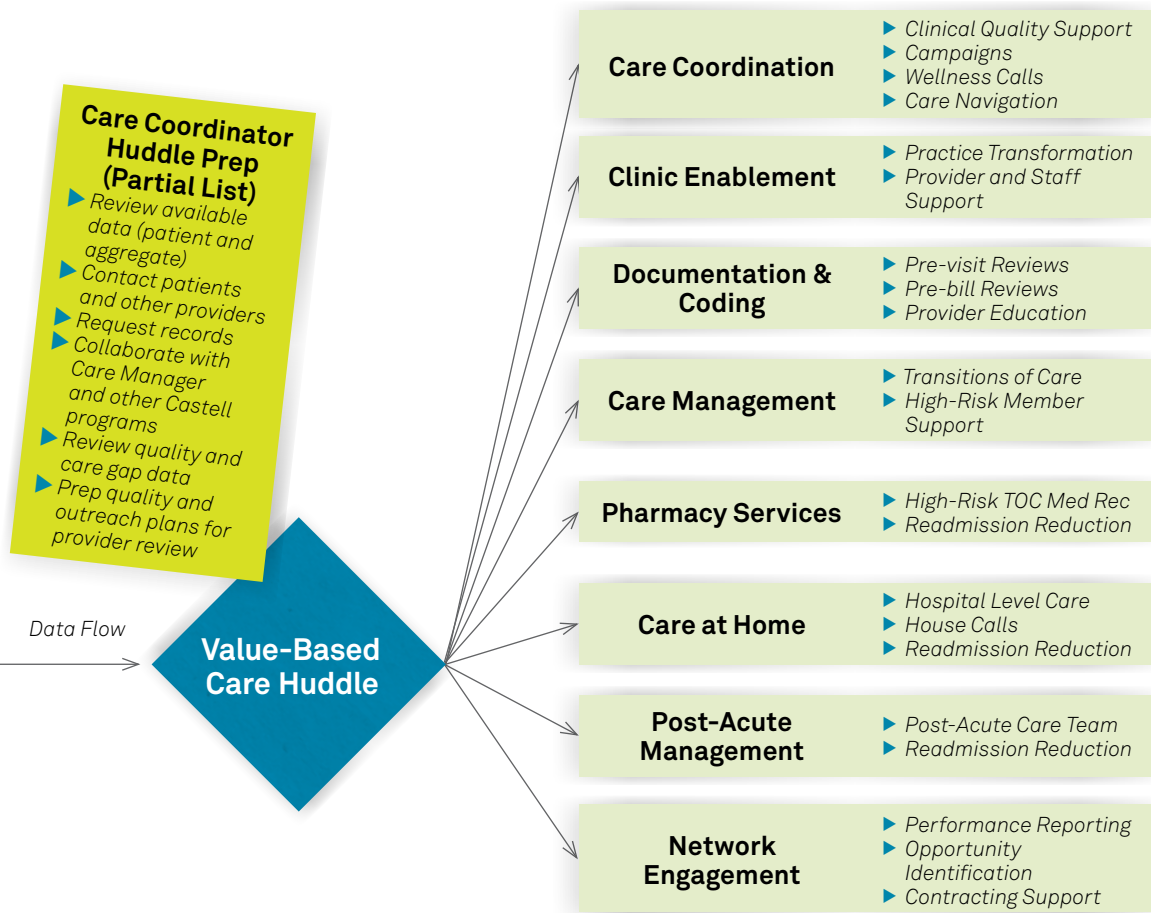
From its beginnings as a pilot to its overall expansion, Reimagined Primary Care rested on five foundational elements:

1. Align incentives across the continuum
2. Restructure teams, panels, core workflows, and processes
3. Educate providers and teams on core tenets of value-based care
4. Deploy novel technologies and advanced algorithms
5. Embed real-time, actionable insights directly into the workflow

### Aligning Incentives

The first element was the alignment of incentives across the continuum of care. According to Daines, "I was going into work every day, not really understanding what financial relationships my organization was in. How much were we in value-based care? How much were we in fee-for-service? We had to do a mapping exercise of where we were in terms of our distribution of fee-for-service and value, where we wanted to go as an organization, and how we were going to get there."

Faced with "a chicken and egg phenomenon," debates centered on whether to start by jumping right in and getting more value-based contracts or going slow and building the clinical competency to manage value-based care. Ultimately, Intermountain settled on doing both at the same time, creating a self-perpetuating system. The more physicians prepared themselves in the clinic to manage value, the more payers would entrust them with value, and the more value they



had in their contracts, the more they could actually build the support to perform in value.

Incentives were then built to reinforce superior performance in those value-based care contracts, focusing on quality, patient experience, documentation and coding, and per member per month target management. This approach was not only for physicians and advanced practice providers (APPs), but also for medical assistants, patient service reps, customer service reps, clinic nurses, and clinic pharmacists.

“Having the whole team aligned to the exact same indicators and making sure those indicators were aligned with what’s in our value-based care contract was a huge step for us,” said Daines. “It yielded a lot of great results, both in terms of actual performance, as well as a sense of teamwork around these shared goals.”

## Restructuring for Value

The next essential element for Intermountain’s value-based care journey was restructuring

how the medical group as a whole looked at the concept of value. This meant having to design a value-based care development plan for the entire medical group, reorganizing how it engaged with payers so that they were leading on a “value foot and not a fee-for-service foot.”

It also meant restructuring how the organization built its financial projections so the trade-offs among fee-for-service, volume, and value generation weren’t regarded as oppositional forces, but as forces that could actually work together for the financial health of the group.

“We had to think about who was on the team in the clinic—who had what role to bring the best value-based care to a patient,” explained Daines. “We had to think about how to help providers. It doesn’t come naturally to everybody to switch from fee-for-service to value-based care. We had to think about how we built for each provider a view of their own success in this transformation. It wasn’t something that should happen to them. It’s something we wanted to happen *with* them.”

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**—Karyn Springer, MD**

Ultimately, Intermountain settled on two custom modes of care: value-based care (VBC) and value-based care plus (VBC+). One care group was set to be exclusively value-based, while the other included a mixture with fee-for-service. “We used this as a way of approaching payers engaging with Intermountain around value—talking to payers about the changes we were making in the clinic or at the bedside,” said Daines. “And by talking about the systemic support systems we were putting in place for patients in value-based care, we could go to payers and say, ‘We think that this model has differential value for your members. You want to be in this model.’”

### Early Challenges

Engaging payers also had its fair share of challenges and difficult decisions. For example if a payer would not choose to enter into a risk arrangement with Intermountain, the medical group would move their patients off value-based care provider panels. Financial projections were also a hurdle—taking what was learned in those initial trials and pilots and then building assumptions on reducing medical expenses, premium changes as a result of accurate documentation and coding, and then connecting and correlating it all with variable or marginal cost within its hospitals.

Preparing for an empty return on investment in initial stages was also difficult. “We had to go and have our finance folks treat us a lot like an investor,” said Henriksen. “We had to say, ‘Look, we can get this return for you, but it’s going to happen in the middle of year two and year three, and you’re going to see more in year four and year five.’”

Intermountain also experimented with care guides: individuals with the capability to talk to patients and who had more personality than clinical knowhow. Standards of work were established for every care coordinator for what they did for outreach, pre-visit planning, and other responsibilities.

### Finding Your Professional Path

In the midst of ironing out all these kinks, Intermountain was still faced with the essential problem of figuring out who were the best providers to take on a fully value-based care

practice and who were the providers who were highly functional in fee-for-service while delivering quality care. This meant acknowledging the reality that not all providers are the same, that many will have differing practice styles, and that autonomy was crucial for buy-in.

Turning to its newly established clinical tracks, VBC and VBC+, Daines said things started “with some wrongheaded thinking that providers were either going to be good at fee-for-service or they were going to be good at value, and then there may be some providers who are in the middle who weren’t quite being successful in either arrangement. We dwelled on this idea for a while that we would have a value track and a fee-for-service track, and they would be totally different.”

Daines described how the divide actually broke down: “We went to our data to map out the relationship between productivity and performance and value to see if there is a relationship. Is it a positive relationship or a negative relationship? We ended up with a visual that showed that there were providers who were highly successful whether you looked at them through a fee-for-service lens or a value lens, and providers that were struggling in both. You really saw everything across the potential relationships between value-based performance and fee-for-service-based performance. What that meant was we couldn’t totally divide it out. We couldn’t take that provider who was doing really well in fee-for-service *and* value and say ‘You have to choose one,’ because you’d essentially destroy their practice. Why fix that if it’s not broken? That’s really where we came to this idea of finding your professional path.”

The leaders of Intermountain took the data at hand and presented them to their providers through a series of town halls. They also had medical directors and associate medical directors share specific data with their corresponding providers, revealing how they were performing in their practice. With this information made available, providers entered what was called a preference process, discussing with their superiors which clinic model best suited their expectations and needs.

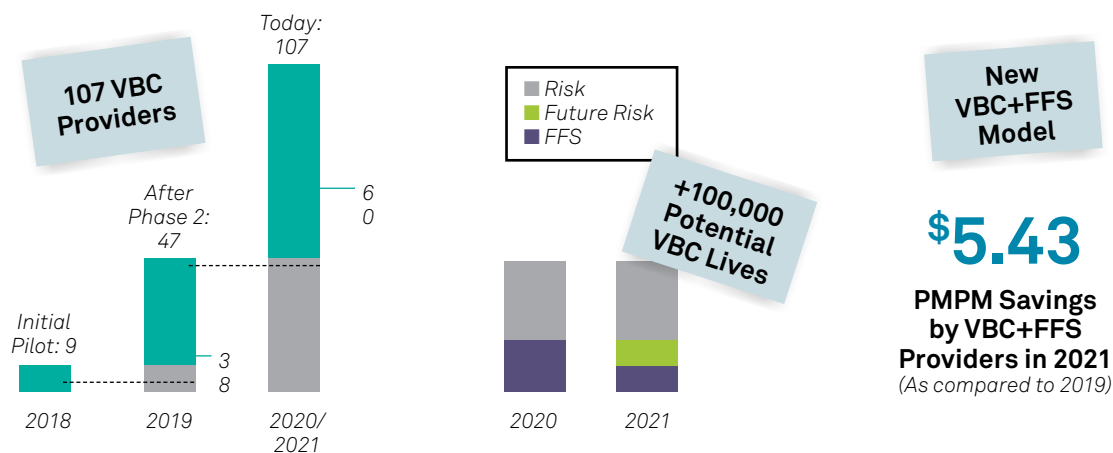
### Educating Providers

After undergoing this extensive restructuring process, Intermountain’s next goal was to



Figure 2

## Success in Value-Based Care at Intermountain



create an official means of education. “One of the things we learned early on is that we use a lot of terminology that nobody understands,” said Henriksen. “When we say value, what does that mean? When we say documentation and coding or HCC, what is that? What is a quality composite?” Employing a series of presentations, a team of practice transformation consultants that could train clinics on an individual basis, and a CME-accredited training blueprint, the organization was able to coalesce its transformation goals.

### Deploying the Models

Moving forward with its new models, Intermountain next had to figure out a way to deploy them that was digestible and actionable. This meant accumulating data from numerous different sources through novel technologies and advanced algorithms (see Figure 1).

“We have a fantastic analytics team that partnered with a vendor to aggregate data across our clinics and insurance companies,” said Henriksen. “We also have a pretty healthy information exchange for hospitals that are non-Intermountain around discharges and admits. We also have some algorithms and tools that are working in the background on top of those. It’s all aggregated in there and spit out into the value-based care huddle.”

### Embedding Insights

All of this hands-on information is designed to create real-time feedback for clinical decision-making. With data available on an electronic dashboard, physicians have insight on care gaps, linking intervention pathways on house calls, to medication reconciliation, and to behavioral health referrals, all integrated into a single workflow.

### Promising Outcomes

With its foundational transformation in place, Intermountain experienced surprisingly fast results in the first 12-month period following the transition, accruing approximately \$2.4 million in savings and a 40% improvement in quality scores. Provider engagement also improved, with some providers moving from the second percentile in their engagement scores to the 95th percentile. Intermountain has seen remarkable success across the continuum (see Figure 2).

Concluding the presentation, Springer shared how a colleague of hers in primary care had recently decided that medicine was not for him—that he had just reached a point of no return in feeling burnt out. Springer said that value-based care really saved him in terms of his engagement and his satisfaction. “That’s the type of thing that we mentioned is super important to prevent that burnout,” she said. “Because it’s good not only for the providers, but also for their patients.” **GRJ**

**Karyn Springer, MD**, is board chair, Intermountain Medical Group, and interim ACMO, Primary Care; **Will Daines, MD**, is medical director, Clinical Operations, Castell; and **Dave Henriksen, MHA**, is vice president, Clinical Operations, Castell, Intermountain Healthcare.