Selecting Value-Based Metrics for Physician Enterprise Success

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Legislation and reimbursement changes seen in the past year signal the ongoing acceleration from volume-based to value-based healthcare. Despite the additional clarification of government payment models for healthcare providers, the operational and strategic implications for healthcare systems, consumers, and commercial payers is uncertain. As in any major industry transformation, success under the "new rules" will require participants to develop innovative skills and capabilities to navigate uncertain times.

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Key Board Takeaways

Five fundamental questions to consider when selecting value-based metrics are:

1. Where is your organization on its journey to value-based delivery and payment systems?
2. What portion of reimbursement is value-based and what remains based on fee-for-service?
3. What are your organization's goals with regard to population health management? Does the primary care enterprise have the capability of managing population care and risk?
4. What role does physician incentive compensation play in affecting change?
5. Does your organization have the technology to collect, analyze, and report data to physicians in order to drive value-based healthcare?

As leaders of healthcare organizations manage this fluid environment, they need to establish short-term and long-term goals and new measurement systems to define success. Physician performance metrics must also evolve as physician roles change from managing "sickness models" of healthcare to leading systems of care focused around population health. These changing roles will redefine what it means to be a successful physician.

A key challenge for physician leaders will continue to be the engagement of physicians in the data analytics and selection of appropriate and reliable performance metrics. Given the hundreds of potential measures to choose from, this process can be complex. However, with physicians actively involved in the selection process and reporting of metrics in a consistent and meaningful way, there is greater potential for success.

This article provides a framework and system of critical thinking that can guide this challenging process. Selecting meaningful performance metrics for providers begins with the future state in mind—achieving population health by providing access to high-quality, affordable care and an outstanding patient experience.

Much at Stake

Overall, provider performance metrics must align with three key elements of an organization's vision and strategy:

1. Business model: What is the strategic direction of the organization and how is it likely to change over the next three to five years? What changes are sought at the individual, team, and enterprise level?
2. Population health: More than just a focus on preventive care or coordination of chronic conditions, a population health strategy defines an optimal patient care experience, clinical quality outcomes, and resource management methods to improve the health of the communities served.
3. Payer reimbursement: How much revenue is still derived from fee-for-service arrangements? All organizations are experiencing transition in which productivity-based payment is still in play. Implementing performance measures, designed to drive quality outcomes, can have a negative financial effect when a number of commercial payer contracts still have volume-based reimbursement provisions. To combat this potentially invalidating effect, organizations need to employ short-term measures that balance the financial realities of existing contractual arrangements with the transitioning value-based reimbursement environment.

Understanding the evolving reimbursement landscape and its implications on performance measure selection is critical. Last year, the Centers for Medicare & Medicaid Services (CMS) announced its intention to accelerate the transition from volume to value reimbursement and the industry took notice. Specific details have now emerged through the recent CMS announcement of a new physician reimbursement system known as the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA will assign organizations a composite score, based 50 percent on quality, 25 percent on advancing care information, 15 percent on clinical practice improvement, and 10 percent on cost. Over the next decade, Medicare will increase the level of reimbursement risk associated with value-based performance up to an additional 9 percent of total fees by 2025.

Many agencies, such as CMS (through the Physician Quality Reporting System) and the National Committee for Quality Assurance (through its Healthcare Effectiveness Data and Information Set) already measure value-based performance through the use of quality and service metrics. MACRA will allow healthcare entities to select a set of six quality metrics, including at least one outcomes-based and one cross-cutting measure.

In addition, physician performance scores are now becoming available to the public through CMS and other agencies. Thus, an organization's chosen metrics have the potential to impact not only its financial performance, but also its reputational strength, and therefore require appropriate oversight including board-level governance.

Four Pillars of Value-Based Metrics

Specific metrics chosen will depend in part on their ability to align physician performance with the elements of organizational strategy noted above. They should, however, also be selected based on the core principles of population health:

1. Access: To receive timely treatment, patients need appropriate access to primary and specialty care. Evening and

weekend clinic hours with 24/7 availability are required to prevent unnecessary emergency room visits and hospitalizations. Telephone consultations and telemedicine provide efficient avenues of patient care and minimize the necessity of on-site office visits.

2. Quality: Measures should relate to four key areas that span the continuum from prevention to acute care. These include:
   - » Healthy lifestyle and disease prevention initiatives, through screening and immunizations
   - » Coordination and management of chronic disease
   - » Hospital care focused on patient safety and the reduction of acquired hospital infection and readmission rates
   - » Medicare-specific measures that address falls, depression, urinary incontinence, and polypharmacy
3. Service/patient experience: The rise of consumerism transforms the patient into the consumer, and heightens the importance not only of clinical outcomes, but of the all-around patient experience. The physician/patient bond centers around mindful listening and is essential in addressing wellness, shared decision making, culturally sensitive care, and healthcare disparities.
4. Affordability: Operational efficiency and resource management is key to reducing costs and achieving the value required by payers. This includes the appropriate utilization of medications and imaging and laboratory testing as well as standardization of processes and tools. Identifying the bases of litigation cases and correcting their causes will improve processes of care and prevent future adverse outcomes.

Choosing Value

Incenting physicians to deliver value—high-quality, cost-effective, consumer-friendly healthcare—is a brand new objective for many healthcare organizations. The selection of performance metrics should be approached with careful consideration that includes an understanding of how each measure aligns with overall strategic and financial objectives. Remember that the metrics themselves should be adjusted and replaced to reflect changing needs and objectives, but they should adhere to the core principles of population health.

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