Performance Enhancement: An Essential Process for Provider Success and Sustainability

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As provider organizations move into greater levels of participation in value-based care (VBC), it is crucial they gauge the clinical and financial success of their investments in patient care, people, and processes—specific to performance related to risk-bearing contracts and reporting measurements.

Performance enhancement (PE) is the identification and quantification of high-level execution, related to contractual and operational key performance indicators, which demonstrates the value customers gain through improved contractual outcomes throughout the risk spectrum and operational efficiency. In today's VBC environment, those organizations that apply PE efforts to their administrative and clinical operations will have a greater opportunity to benefit in contract performance, including financial and quality of care.

PE efforts in provider organizations are driven, often successfully, through the application of performance enhancement opportunities (PEOs). These efforts work with the capabilities, protocols, and workflows of healthcare organizations and provide advanced insights. Provider organizations seeking PEOs can realize and capitalize upon PE applied through their own teams, as well as through consultants and vendors they hire.

The Healthcare System's Shift to Value-Based Care

The shift from fee-for-service (FFS) to VBC began back in April 2005 with the Medicare Physician Group Practice (PGP) Demonstration. After five years, the Affordable Care Act provided a stronger move to value by authorizing the Medicare Shared Savings Program (MSSP), which formally began in 2012. From that time until today, there have been additional efforts—and subsequent growth in payments related to value.

The COVID-19 pandemic has, in many ways, served as a catalyst, driving a sharp rise from a foundation of volume to value in care services and compensation. A study from HCPLAN, representing 238 million Americans or 80 percent of the covered population, shows that more than 60 percent of all healthcare dollars are now tied into some form of value-based reimbursement.[1] This includes models of population-based payments, shared risk, bundled payments, and shared savings. Moreover, many studies and surveys reflect greater success in clinical and administrative operations in VBC relating to those health organizations able to gain greater access to, use of, and generate crucial insights from data.

This is echoed by a November 2021 Guidehouse survey, where 36 percent of health system CFOs report the number one challenge around the adoption of VBC is their ability to transform data into actionable information.[2] Effective identification of PEOs should include solutions enabling healthcare data to be integrated, harmonized, normalized, and made actionable. This is where the PE process shines—in protocols linked to contractual, quality, and value drivers of VBC and pay-for-performance arrangements for providers.

Whether by choice, need, or both, as providers continue to transition from traditional FFS, they must intelligently straddle their transition to perform well in VBC agreements for future cost reduction shared savings, while driving appropriate present FFS revenue to the organization.

Successful employment of PE focuses on areas that matter in maximizing that value—including contract negotiation and reconciliation, appropriate risk coding, cost-of-care opportunities, quality performance, optimizing FFS utilization, network management, technical infrastructure, workflow efficiency, and more.

This article provides a proven five-pillar PE framework for management teams of provider organizations who seek to attain and sustain strong results—within growing levels of VBC—through PE and PEOs. These efforts also include crucial insights, which provides management with an ability to deliver accurate, timely, and insightful reporting, on a high level, to the board—related to the organization's performance within VBC.

Key Board Takeaways

- Ensure awareness and understanding of the healthcare organization's current levels of participation within programs and contracts involving VBC.
- Receive accurate and regular reporting on investments, expected outcomes, goals, and clinical as well as financial results of VBC participation.
- Know the strategy management uses to mitigate risk and meet and exceed performance metrics, related to success in VBC contracts and programs.
- Recognize that performance enhancement, by improving workflow efficiency, is linked to challenges in staffing and clinical team burnout.
- Ensure transparency to make sure that management has the right resources to manage success in current and growing levels of VBC involvement.
- Create guardrails for intervention, from the board to management, when red flags or poor results arise in select areas.

Performance Enhancement Opportunities: Driven by a Five-Pillar Framework

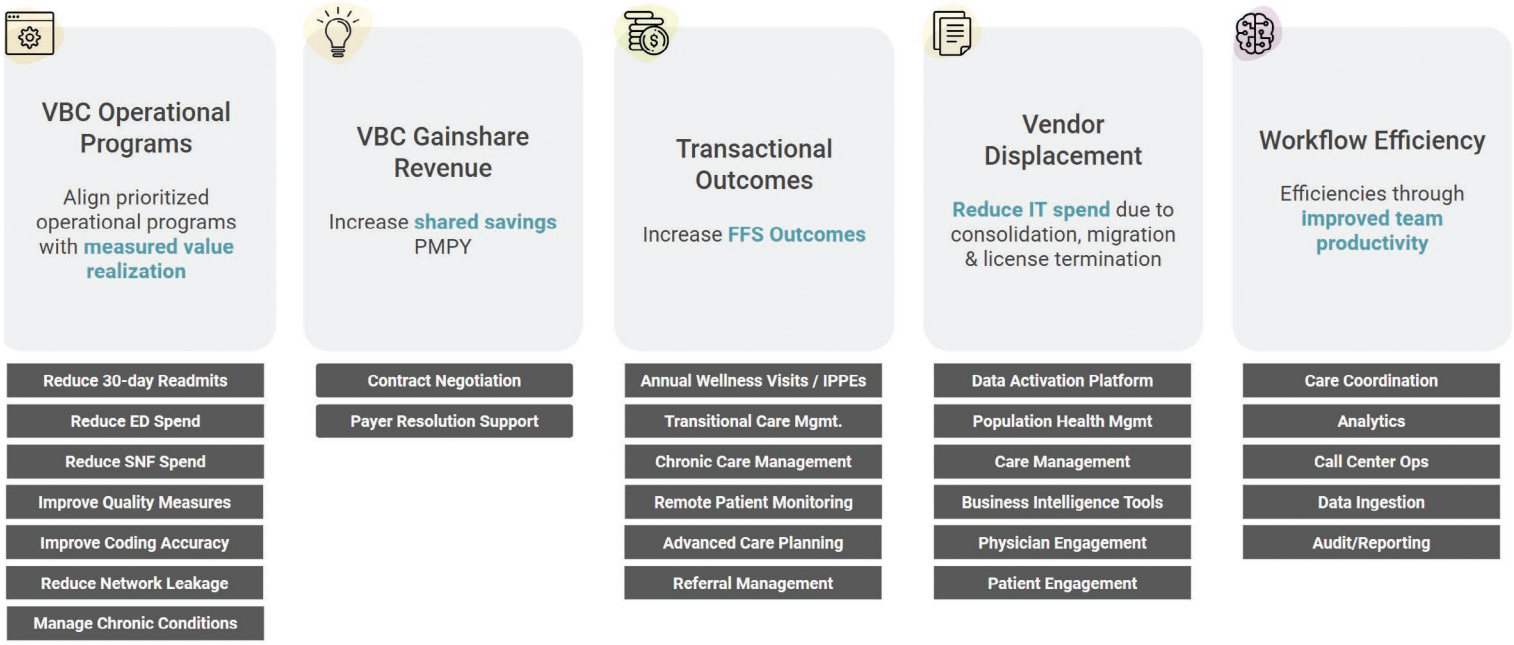
In the framework, there are five PE pillars, each supporting a group of underlying and specific value levers. When vendors utilize PE, the value levers of specific pillars are applied and run as recommended protocols in clinical and administrative efforts. This results in improving and optimizing specific workflows, monitoring and measuring results through standardized analyses and quarterly reviews, effective benchmarking to collaboratively build upon successes, as well as the shared contribution and development of best practices.

Pillar 1: VBC Operational Programs

In population health, avoidable events occur at a dynamic baseline within a cohort of patients. Strategic programs

1 HCPLAN, *2020–2021 Methodology and Results Report*.
2 Guidehouse, *2021 Risk-Based Healthcare Market Trends*.

Exhibit 1: Five-Pillar Performance Enhancement Framework



and protocols can drive realized value from the tangible movement in key metrics for cost and performance, such as reducing 30-day inpatient readmissions with increased care coordination at the time of discharge.

A comprehensive triage consisting of a deep analysis of an organization's current value contracts, operations, and processes inform on the potential PEOs built on transparent, repeatable, and industry-accepted approaches. Value levers in this pillar of the PE framework drive performance on VBC contracts and include:

- Reducing 30-day inpatient hospital readmissions
- Reducing emergency department (ED) and skilled nursing facility spend
- Improving coding accuracy
- Improving quality measures
- Reducing network leakage
- Managing chronic conditions

Reducing ED spend is an important lever around optimizing ER visits, where you can have capacity for the appropriate types of patients being seen, but also reduce the unnecessary visits that drive up cost. This lever indirectly helps balance the interests of a provider organization's financial and population health operations to properly blend within revenue and cost, and more broadly for smartly balancing provider participation within FFS and VBC models.

As seen in **Exhibit 2**, a vendor deployed a PE effort for a management services organization (MSO) helping providers uncover value within their 30-day readmissions. Utilizing the appropriate value lever from the first pillar, the MSO realized substantial decreases of 19 to 39 percent from baseline to final readmission rates (yearly).

This decrease was realized across the MSO's Medicare NextGen ACO, Medicare Advantage, and MSSP contracts. It resulted in a performance enhancement of more than $3.3 million in two years—solely by effectively lowering 30-day readmissions and ED costs, through a select group of protocol participants. Additional benefits—in the form of improved care quality and outcomes—are realized when patients in this type of PE effort avoid the hospital and ER. Note the year-over-year increases on ROI. This happens from the optimization of best practices, as well as increased protocol participation across a wider number of plans, involving more individuals and addressing more operational workflows.

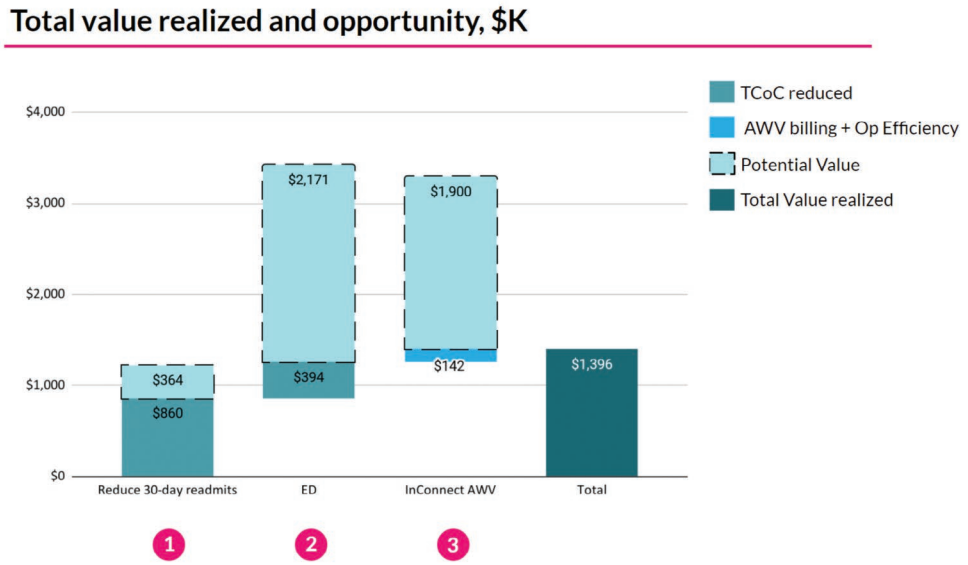
As seen in **Exhibit 3** on the next page, A medium-sized health system ran two value levers from the operations program (pillar 1). This resulted in the provider organization realizing just over $1.25 million in value by reduced 30-day readmissions and decreasing ED spend.

The first value lever run, for 30-day readmissions in a transitional care

Exhibit 2: Case Study of MSO 30-Day Readmissions

	2020			2021		
	NextGen	Medicare Advantage		MSSP	NextGen	Medicare Advantage
Baseline readmission rate	16.80%	14.00%		14.30%	16.20%	14.60%
Final readmission rate	13.30%	11.40%		8.70%	12.50%	11.20%
Percentage improvement	21%	19%		39%	23%	23%
ROI	3.0	2.7		4.5	3.6	3.9

Exhibit 3: Case Study: Health System with Reduced ED Spend, Readmissions, and More Annual Wellness Visits



1. **Reduce 30 day readmits** by ~43% in the intervened populations in 2021, generating $860K in value.
2. **Reduce ED spend:** Reduced total cost of care by 84% in CMS and 34% in commercial populations, 1 month following intervention.
3. **Improve AWV:** Captured an additional 1,355 AWV's with an estimated $142K in FFS and operational efficiency gains.

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management protocol, led to $860,000 of realized value and $364,000 or 42.3 percent of potential realized value. This specific lever was run across two different hospital groups in the health system, further refined through a select number of patients assigned, who were insured by Medicare or a single specific commercial plan.

The second value lever run, for reducing ED spend, reduced the total cost of care by 84 percent in CMS populations and 34 percent in commercial populations, in just one month after running the recommended protocol. The provider recognized nearly $400,000 in performance enhancement, and $2.1 million of realized value with program expansion.

Through effective protocol deployment through the framework, health professionals come to not only realize value, but often see a significant spread between realized and potential realized value. A difference that points to all that is being left on the table if they were to have maximized the recommended protocol usage.

It's a big reason why the use of an effective PE vendor often starts small and continues to grow throughout application across different parts of a healthcare organization.

Pillar 2: Contract Performance Revenue

The value levers within this pillar apply to live PEOs for providers, delivered through a bookends approach throughout the measurement period with payers in a value-based contract.

The front end of this approach focuses on contract negotiations and the back end reflects on live efforts applied within performance dispute resolutions. And because those effectively utilizing PE should have experience working on both sides of the provider-payer contract, they will be familiar with where to find extra money and opportunities.

For example, a common challenge experienced by providers in value-based contracts occurs when payers incorrectly

attribute patients, ICD truncations, and quality gaps when reconciling payer performance. Here, the organization synthesizes claims experience to find opportunities for carve-outs. They also equip clients—providers or vendor MSOs—with a shadow file gap analysis, contract methodology check, and regional benchmark data, to check against payers on reported results.

Pillar 3: Revenue Enhancement to Fund Population Healthcare Infrastructure

This pillar connects into the VBC operations program (pillar 1) by measuring transactional revenue outcomes under FFS, while contributing to value-driven performance. Value levers relating to services—including annual wellness visits and initial preventive physical examinations, transitional care management, chronic care management, remote patient monitoring, advanced care planning, and referral management—help keep revenue in the system, as well as driving appropriate care.

Though not often being the largest contributor to dollars saved, this pillar and its levers bring value through increasing patient connection to the system. Specifically, by helping to improve patient–provider trust and

relationships, closing potential care gaps, and adding revenue that may lead to total cost of care savings.

Case Study: Growing Annual Wellness Visits

Utilizing PE efforts through PEO, a private, not-for-profit network of community and specialty hospitals, with a hard-to-reach population, increased the employment of annual wellness visits across a population of 10,000 patients. Apart from an increase in revenue, this lever drives greater coordination with patients on:

- Noting/scheduling screening appointments
- Identifying risk factors for present and future health
- Reviewing current providers and prescriptions
- Optionally, addressing advanced care planning

Pillar 4: Vendor Optimization

A recent report from Morning Consult revealed that 97 percent of healthcare executives are making digital transformation a key focus area. Greater investments will be made into data readiness and interoperability, as three out of four note the need for reducing siloed data—and making their data more actionable—as the industry moves from a foundation of volume to value.

Many organizations are investing in a data lake to pull together and aggregate data from their many transactional systems. This requires a heavy investment in core data plumbing to establish data semantics that drive insights, and without this investment, the data lake can become a data swamp with significant challenges in driving organizational consistency in terminology and analytics stewardship.

Integrated solutions, consolidation, migration, and license termination of other vendor technologies offer strong opportunities for performance enhancement through decreased net IT spend and increased contextualization. One significant opportunity in this space is effective health cloud participation. When compared to internal efforts—with or without consultants—provider organizations save up to 80 percent in implementation time, and there is as much as a 75 percent decrease in costs to create and maintain.

Pillar 5: Workflow Efficiency

High-quality data management and processes (putting the right information in the right hands at the right time) increases productivity gains across teams. Such efforts help care coordination teams automate protocol assignment from admit, discharge, and transfer messages, eliminate time spent manipulating Excel sheets, and/or other key steps like pre-visit planning to review open gaps. Value levers within this final pillar include:

- Care coordination
- Analytics
- Call center operations
- Data ingestion
- Audit/reporting

Case Study: Increasing Efficiency and Saving Costs

PE, in the form of greater efficiency, lower costs, and increased output, is a critical need for operational leaders and managers—especially for today's challenges in staffing and retention, coupled with rising costs, regulation, and reporting requirements in VBC.

Utilizing recommended value levers in this pillar, a physician-led healthcare services organization increased care coordination team productivity and efficiency. In a year-over-year analysis of pre- and post-PEO efforts, the number of care protocols rendered, per full-time care coordinator, went from 565 to 643. This year-over-year 14 percent increase in productivity was realized through more efficient processes.

Performance Matters

Boards have ever-increasing responsibilities around making sure that their organizations are succeeding in financial, clinical, risk, and operation. Nowhere is this more important than within the shift and participation around risk-based programs in VBC. Success requires leverage, risk mitigation, greater levels of data readiness, and knowing where to make the right investments in infrastructure.

Performance is a major lynchpin for improving success in VBC—and PE plays a crucial role. PE, as a management-driven process, addresses value drivers of opportunity in non-optimized areas such as readmissions, network leakage, transitional care management, and much more.

Many boards face ever-shrinking operating margins, challenging requirements and leverage on payer contracts, provider burnout, and expectations around metrics and results—linked to payment. Management needs to identify, improve, and accurately report on the value-based "health" of an organization back to governance. PE drives better levels of data readiness and insights, which fuel greater guidance for organizations navigating their journey to value.

The Governance Institute thanks Brian Silverstein, M.D., Chief Population Health Officer, Innovaccer Inc., and Governance Institute Advisor, for contributing this article. He can be reached at brian.silverstein@innovaccer.com.