

This is a sample of the instructor materials for *The Core Elements of Value in Healthcare*, by Paveljit S. Bindra.

The complete instructor materials include the following:

- Test bank
- PowerPoint slides for each chapter
- Instructor guides (with answers to discussion questions)

This sample includes the PowerPoint slides and instructor guide for Chapter 1, “Approaching Value-Based Care.”

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to [hapbooks@ache.org](mailto:hapbooks@ache.org) and include the following information in your message:

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# Chapter 1

## Approaching Value-Based Healthcare

# Goals

- Recognize the “iron triangle” of value in healthcare (better quality, lower cost, and better access)
- Understand the historical evolution of US healthcare
- Define value in healthcare
- Compare models of healthcare delivery that focus on delivering value
- Demonstrate how pay-for-performance can encourage value in healthcare
- Examine the changes needed in the current healthcare delivery system in the movement to enhance value

# Volume-Based Healthcare

- A traditional healthcare paradigm in which consumers and providers seek to maximize the volume of services provided
  - Fee for service
  - Focus on volume, not outcomes
  - Leads to overutilization
  - Unsustainable in the long term

# Value-Based Healthcare

- An approach that seeks to reduce the cost of healthcare delivery while increasing quality of care and patient satisfaction
  - Moves away from “more is more” mentality in healthcare
  - Drives sustainability in healthcare organizations
  - Introduces a quality and value paradigm
  - Will need evolution in finance, operations, strategy, quality

# Value in Healthcare—Definition

- Value: Health outcomes achieved for every dollar spent
- Iron triangle
  - Better quality
  - Lower cost
  - Better access
- Costs reflect entire cycle of care for a patient's medical condition
- Must account for the risk profile of the population being served
- Processes are important but outcomes are more relevant; processes are a means to better outcomes

# Requirements for Value

- Transparency—Results should be shared and easily available to the consumer
  - Will improve care
  - Accelerate innovation
  - Engender healthy and beneficial competition for race to the top
- Holistic—Tie together processes, outcomes, access, risk, and cost
  - Will identify structural cost-reduction opportunities
  - Eliminate non-value-added services
  - Better capacity use

# Expanding the Pie

- Traditional healthcare economics assumes a zero-sum game
  - Resource “pie” is fixed; one organization’s gain is the other’s loss
  - Silos
  - Tragedy of the commons: Each entity maximizes its own good to the detriment of the whole
  - Specialists, hospitals, providers, payers all compete to overall detriment
- Competition should be measured for value delivered in treating the overall disease
  - Knee surgery, for example: Focus not on departmental success but surgery success
  - Time to diagnosis, treatment, and recovery
  - Will force interdepartmental collaboration



# Value-Based Competition

- Delivery is geared toward the patient
- Competition should be results oriented
- Care should encompass the entire disease spectrum
- Care should be less expensive
- Outcomes should be measured at the provider level
- Competition should be regional or national
- Outcomes data are transparent
- Performance-based incentives related to outcomes

# Recent Moves to Value

- Increased managed care
- Affordable Care Act
- Accountable care organizations
- Health exchanges to improve access
- Websites for transparency
- Value-based purchasing—linking of payment to quality outcomes
- Bundled payments

# Innovations to Eliminate Waste

- Clinical innovations
  - Care coordination
  - Readmission prevention
  - Palliative care
  - Care transitions
  - Patient-centered medical homes
  - Patient education and outreach

# Innovations to Eliminate Waste

- Financial
  - Pay for performance
  - Providers are compensated for care based on outcomes
  - Incentives for better care
  - Use of processes that minimize wasteful care
  - Penalty for poor outcomes
    - Readmission penalties
    - Complications lead to lower reimbursement

# Innovations to Eliminate Waste

- Health insurance and payment reform
  - Essential health benefits:
    - A set of benefits for any health insurance product being sold in the marketplace
    - Cost sharing innovation to encourage value based behavior by the consumer as well
    - Provider tiering
    - Data transparency
- Supplier implications
  - Suppliers to focus on entire cycle of care
  - Use evidence of long-term clinical outcomes and cost to show value
  - Outcomes research and comparison

# Innovations to Eliminate Waste

- Implications for consumers
  - Patient activation
    - The knowledge, ability, and willingness of patients to manage their own healthcare
  - Patient engagement
    - The active involvement of patients in their own healthcare and in activities and decisions that support their health

# Innovations to Eliminate Waste

- Change management
  - Leaders must understand value-based care
  - Communication
  - Collaboration
  - Comfort with uncertain change
  - Versatility with information technology
  - Process data to create information to create knowledge
  - Audit ready
  - Accountability
  - Operational effectiveness
  - Overcoming resistance
  - Personal leadership
  - Motivation
  - Integrity
  - Being realistic

## ***THE CORE ELEMENTS OF VALUE IN HEALTHCARE (BINDRA 2018)***

### **ANSWERS TO END-OF-CHAPTER DISCUSSION QUESTIONS**

#### **Chapter 1 Discussion Questions**

1. Discuss whether process measurements in value-based purchasing are useful. Should outcomes measurements completely replace process measurements?

*Process measures can help with hardwiring processes in organizations. As measures change, if organizations ensure the processes already implemented are hardwired, then there should be continuous improvement. However, it is outcomes that matter. If the processes implemented are very good but outcomes are still poor, then, in the long term, the support for the process measures is bound to erode.*

2. What strategies should healthcare organizations pursue to ensure that the incentives of key stakeholders are aligned to deliver value? How does misalignment create perverse incentives that destroy value in healthcare?

*There needs to be financial, organizational, philosophical, strategic, and operational alignment. Without this alignment, all stakeholders will try to maximize for the benefit of their interests and end up hurting the overall welfare of the entire system. Strategic realignment of payers and different levels of providers is needed so that all parties can come to the table to ensure that waste is eliminated while maintaining revenue and income while maximizing the quality of care that is being delivered.*



*Students should be able to discuss value based and volume-based care. They should explain how volume-based care incentivizes more care being delivered that is not necessarily improving morbidity, mortality, or the patient experience. Then a discussion around the meaning of value-based care should touch upon rewards to stakeholders who eliminate waste and enhance value.*

3. Many experts believe that healthcare, given its competitive nature, is a zero-sum game. Discuss whether a focus on value can shift the paradigm away from this zero-sum mentality. Provide examples of how this shift may occur.

*Students should explain the meaning of value-based care. Healthcare can be considered zero sum in volume based care, since there are fixed dollars available and they either go to a payer or a provider. A value-based system should optimize work to those best suited and qualified to do the work. So the quality and outcomes should be better. Examples include bundled payment, managed care, ACOs, patient-centered medical homes, and risk-based contracts.*

4. Although value-based health delivery is a laudable goal, it is possible that the cost for an organization to comply with the paradigm may exceed the benefit. Is a form of penalty needed to ensure that healthcare organizations comply?

*Students should address the fact that, ultimately, a business must be sustainable so that revenue exceeds costs. Discuss the risk that organizations may pursue high investments to deliver value but move beyond a model dependent on cash from operations.*

*Investments in such areas as IT, disease management programs, and care coordination,*

*while laudable, have high cost, and the benefits may be noted several years later. Many organizations might not have that staying power. Contracts must be set so that there is a sharing in any savings and risk-adjusted payments. Penalties may also be needed, as in the value based purchasing initiatives, so that management is forced to invest in harm prevention.*

5. Discuss how shared savings can provide alignment among providers to deliver value-based care to patients.

*There is a predetermined amount of funds available for care delivered to beneficiaries, and it can be shared between payers, providers, and other stakeholders. If all stakeholders have a contractual relationship whereby any funds saved through the efficient delivery of care are distributed proportionally between them, then shared savings are said to exist. This situation should encourage the efficient and cost-effective delivery of care. The important caveat is that strong protections should exist to ensure that care is not being withheld.*

6. Why does the patient experience matter in the calculation of rewards and penalties in value-based purchasing?

*Ultimately, the patient is the consumer of the care being delivered, and all initiatives are geared toward ensuring that the patient is receiving effective care that leads to good outcomes. The patient experience is a holistic surrogate marker for outcomes. Efficient, effective care with good outcomes tends to be reflected in better patient experience*

*scores. If penalties and rewards are linked to the patient experience, stakeholders get the message that this outcome component is important and needs to be addressed.*

7. Consider the following case: Plumeria Inc. is a local employer of more than 5,000 employees that manufactures metal parts for automobiles. It provides health insurance for its employees and their families. Over the last five years, the premium costs of the insurance have been rising at an average rate of 30 percent annually. Next year, the premium is expected to rise another 28 percent. Health benefits now account for more than 30 percent of the cost structure. The operating margin for the company is 3 percent per year. Revenue growth during the same period has been 8 percent per year. Health costs have grown faster than revenue growth. The company's chief financial officer has advised that next year's budget will show a 1 percent margin, and if the cost structure does not improve, the company will operate at a loss in two years. Leadership has identified that, along with a general cost-cutting strategy, a targeted reduction in healthcare costs is critical to ensure sustainability and profitability. You are the company's chief human resources officer.

- a. What strategies can be used to reduce the cost of healthcare? Your answers should include current strategies in the marketplace as well as value-based options. You can extrapolate from the discussion in this chapter as well as your research of the available literature.

*Responses will vary. Students should include discussion about employee engagement and education. These concerns are important so that the consumer is better informed. Other options include incentives for employees to engage in*

*healthy activities such as walking, exercise, and appropriate weight maintenance, through lower cost sharing (copays, premiums); a tiered provider network where providers with better process, outcomes, patient experience, and efficiency scores are placed in higher tiers with lower cost sharing for employees; and contracting with providers so that shared savings and value-based contracting are in place.*

- b. You are considering a value-based benefit design, and your health insurance company is willing to explore this option. Provide a framework that may be successful in engaging your employees to accept such a program. What features will you include in this product? What challenges can be expected in rolling out such a plan?

*Refer to page 337 for a description of the value-based insurance design (VBID) program. The reader is also encouraged to read the article by Chernew, Rosen, and Fendrick (2007), referenced in the book. Features of the VBID program may include a formulary with differential pricing to encourage better medication utilization through lower or no copays. Other options include reduced or eliminated copays for members entering disease management programs, such as for chronic diseases (e.g., diabetes, congestive heart failure). Challenges may include patient education and involvement, operationalizing the VBID features and tracking the program, ensuring that cost savings to patients are meaningful enough, creating a large enough network of providers who are in the upper tier, and providing network adequacy for the members.*

- c. Delineate a rollout strategy for the insurance design. Your strategy should include a communications element, and it should specify the roles various stakeholders will play in ensuring the design is accepted.

*Responses will vary. They could involve identifying members who would benefit from a VBID program. Selection criteria would be needed, possibly including total cost, number of chronic conditions, and medications. Communication that is nondiscriminatory and consistent with current programs such as the CMS VBID pilot ongoing would be a possible answer. Stakeholders include the providers, employees, their dependents, and leadership in the organization.*

- d. What metrics will be important in monitoring the success of this product? Create a dashboard that will be used by senior leadership to track adoption, medical and administrative expenses, and general health of the membership insured. Consider metrics such as medication compliance rates, use of preventive services, use of health and disease management programs, and use of high performing providers.

*Metrics should incorporate patient satisfaction, process measures for specific disease conditions, outcomes related to the targeted conditions, and cost per member per year. Enrollment into the programs such as the VBID program should be tracked over time. Medical and nonmedical (administrative) expenses should be reported. Fill rate of prescriptions should be reported. Utilization of providers in the high-performing category, in terms of percent of all encounters, should be tracked as well.*

- e. Provide a strategy you will use to promote acceptance of this initiative.

*Discussion should include a written and town hall communication strategy to educate the membership about the benefits of the program. Transparency around potential challenges should be ensured to improve credibility. Addressing challenges instantly will be important. An adequate network, communication of successes, and ambassadors for the program from within the consumer base will be important.*

- f. Consider the milestones that must be achieved to reduce the cost of the health insurance being provided. Provide a timeline that is realistic.

*The first year would be the base year. The year prior should be used as a comparison for cost, patient experience, and medication compliance. Process measures can be measured the first year and used as a comparison for subsequent years. Outcomes would be better measured the second and third year. Meaningful assessment of results will depend on the extent of change and membership included to reach statistical significance.*

- g. Write a three-page memo outlining the strategy, techniques to measure progress, expected benefits, and anticipated challenges.

*Responses will vary and should incorporate the discussion from parts a–f.*