A Model for the Transition to Value Based Care

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Executive Summary

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| **Background** | The majority of US medical payment models involve a fee-for-service reimbursement system. In this model, healthcare expenditures have continued to rise in recent years. There has not been a commensurate improvement in clinical outcomes and quality of care continues to lag behind other countries. Several attempts have been made to curtail healthcare expenditures in recent years; however, they have not ultimately proved effective. Therefore, a novel model of healthcare delivery has been proposed and is beginning to be utilized in a few sectors of medical care—this new model is termed value-based care (VBC).  
VBC is an exciting alternative payment model that is beginning to reshape how medicine is delivered. One of the major challenges is reorganizing care delivery and developing processes that can be standardized and measured. For this approach to be successful, there needs to be a strategy to educate providers and stakeholders so that they will embrace the necessary changes to produce a grass roots, bottom up approach to successfully provide outcome-based care at lower cost. |
| **Methods** | Our approach for this project on the transition to VBC within the Duke University Health System was initially orchestrated through multiple in-person meetings with our 7-member DCLP team plus our coach Mira Brancu, PhD and our sponsor Sara Holleran, MPH. Following initial in-person meetings, we had frequent email correspondence and transitioned to virtual Zoom meetings over the lifecycle of this work. In order to finalize our project recommendations, we developed and implemented a 4-step process as follows:  
1. Conducted background research and stakeholder engagement  
2. Performed a baseline assessment of VBC knowledge across diverse Duke Health providers  
3. Defined our deliverables  
4. Pivoted to support project transition |
| **Risks and Alternatives** | We believe that it is vital for the transition to VBC to be provider-driven with a focus on quality of care and clinically relevant outcome measures. If no action is taken to appropriately educate providers on the benefits of VBC, provider buy-in will likely be low and ultimately will affect the institution’s ability to successfully transition to value-based care. Should adoption of VBC principles and practices be delayed, or worse, not undertaken, Duke University Health System would likely face considerable financial risk and loss of market share.  
Our group considered a patient-focused toolkit as a method to encourage adoption; the thought being that patient choice in a VBC marketplace would drive provider behavior. While patient understanding and acceptance of the changes associated with VBC are certainly important, our group felt an effective patient education toolkit would be more challenging at best and potentially even less impactful than the education of providers. We also believe that providers who are well educated regarding the potential positive results that VBC will make in their patients’ lives will be in an ideal position to influence patient perception in favor of VBC. |
| **Recommendation** | The deliverables that our team focused on consisted of three parts. The first was a Toolkit in the form of a PowerPoint or Word document designed for Chairs or Division Chiefs to help them to better understand what questions to ask and what information to provide to their group (VBC definition, real world examples, financial incentives, etc). |
The second item was an inspirational video, designed to be between 3-5 minutes long that could be shown to broad groups of providers to educate and engage them around VBC. The last deliverable was to start the process of creating a seed grant for novel VBC ideas that could be developed and piloted at Duke.

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<th>Next Steps and Key Elements of Success</th>
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<tr>
<td>Our workgroup felt there were three critical elements necessary in order to ensure this partnership would be successful:</td>
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<tr>
<td>1. Provider buy-in</td>
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<tr>
<td>2. Local control and provider ability to affect change</td>
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<td>3. Health system support and reinvestment</td>
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<td>Perhaps the greatest obstacle that has been echoed throughout our work, is provider buy-in. This seemed to us the first and most essential step and hence where we focused our initial efforts. To help assuage provider concerns and fears of VBC, we felt it necessary to assess their current knowledge and then based on those results, design a toolkit to help providers better understand what VBC is and how it meets our common goals of providing higher quality and lower-cost care.</td>
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<td>Our plan was to provide as our final project both written materials as well as a short informative video to providers. These items were to highlight that while VBC may be coming regardless of our individual apprehensions, there is much we could contribute during this organizational time to affect positive change. With a sense of comradery and partnership with the health system, provider buy-in will be more feasible.</td>
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<tr>
<td>With the adjusted timeline, we would encourage next year’s team to continue along the lines of establishing provider buy-in and following through with a finalized toolkit and video product.</td>
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Background

Currently, the majority of US medical payment models involve a fee-for-service reimbursement system whereby an institution is paid directly for the volume of work performed. In this model, healthcare expenditures have continued to rise in recent years. Nevertheless, we have not seen a commensurate improvement in clinical outcomes and quality of care continues to lag behind other countries in important domains. Several attempts have been made to curtail healthcare expenditures in recent years; however, they have not ultimately proved effective at reducing cost to the extent needed. Therefore, a novel model of healthcare delivery has been proposed and is beginning to be utilized in a few sectors of medical care—this new model is termed value-based care (VBC).

The basic concept of VBC is to maximize value of healthcare for the patient. Value is created by demonstrating improved, reliable outcomes and linking the cost of the treatment to the particular disease or procedure. This patient-centric approach emphasizes patient experience and outcomes to validate that the intervention/care that is provided makes a demonstrable difference while tying that treatment cost to the care delivered, rather than simply offering a co-called blank check for procedures performed without accountability.

This new paradigm is transforming the healthcare system from one largely based upon individual providers functioning independently into an innovative and organized system that functions as a team to more efficiently and effectively treat disease processes. The blueprint for providing value-based care has been achieved in some healthcare systems but has been slow to gather traction in others. In a VBC model, payments will be bundled around the process rather than the individual procedure performed to encourage health systems to be accountable for the end result through measurable outcomes. The transition often involves bundled payments, creating integrated practice units, organizing care delivery throughout a health system and tracking outcomes. This novel performance-based reimbursement will ultimately drive change because at its core, creating value and showing impact will drive reimbursement.

A case example of VBC could be an integrated unit set up for back pain. Any patient with low back symptoms would be able to call a central number to be efficiently scheduled with a provider using a standardized protocol, allowing optimal patient access with the most appropriate escalation of care. This would reorganize service lines around patients’ needs. The designated protocol would involve multiple providers including advanced practice providers (APPs), physiatrists, surgeons, physical therapists, dieticians, pain specialists, oncologists, endocrinologists, rheumatologists, and pain specialists, among others in the same clinic. This would allow improved efficiency, more optimally utilize resources, all while improving the patient experience, standardizing care, and providing trackable outcomes data. Virginia Mason Health Clinic organized a low back pain clinic similar to the above proposal and showed that patients missed fewer days of work, needed less therapy, and reduced cost while improving the patient experience (https://www.virginiamason.org/spine-clinic). Similar organization could be made around other disease processes such as diabetes, Crohn’s disease, smoking cessation, and procedures like cardiac catheterization, and hip replacements.

Value-based care is an exciting alternative payment model that is beginning to reshape how medicine is delivered. One of the major challenges is reorganizing care delivery and developing processes that can be standardized and measured. For this approach to be successful, there needs to be a strategy to educate providers and stakeholders in hopes that they will embrace the necessary changes to produce a grass roots, bottom up approach to successfully provide outcome-based care at lower cost. Our strategy to facilitate this transition included an educational video, a provider tool kit and a starter grant to encourage new projects within the Duke Health System.
Method

Our approach for this project on the transition to value-based care (VBC) within the Duke University Health System was initially orchestrated through multiple in-person meetings with our 7-member DCLP team plus our coach Dr. Mira Brancu. Following initial in-person meetings, we had frequent email correspondence and transitioned to virtual Zoom meetings over the lifecycle of this work. In order to finalize our project recommendations, we developed and implemented a 4-step process as follows:

1) Conducted background research and stakeholder engagement
2) Performed a baseline assessment of VBC knowledge across diverse Duke Health providers
3) Defined our deliverables
4) Pivoted to support project transition

Throughout this process, we strengthened our collaborative, team-focused relationship and had multiple key learnings regarding the nature of team-based project work as summarized below.

Our first step in the project involved background research through two phases. Phase A involved a literature review and evaluation of current data across the healthcare landscape. We assessed available resources across multiple different mediums including key summary articles from the NEJM and JAMA. We also reviewed publicly available presentation slide-sets on VBC and lay-press publications. We then explored output from recent Summits on VBC and further narrowed our scope to recent Duke Health and PDC presentations, fact sheets, a recently launched toolkit and a contemporary Medicine Grand Lecture focused on VBC (Drs. McClellan and Patel; Feb 14, 2020).

Given the diversity of resources available, our group use a Box folder to upload documents and then we each sent our summary emails to highlight the key lessons from our parallel research efforts. This approach allowed us to more efficiently expand our individual knowledge while also supporting team-based alignment over time. Here is an anonymous quote from one member of the team which nicely summarizes the value of different articles and lessons learned while also highlighting the uncertainty of the group at this early stage of the project:

“The two [recent] articles in the Box are pretty high yield and easy reads.

1. Harvard Business Review - Explains value and the move from fee for service and introduces integrated practice units. Also discusses measuring outcomes that are valued by patients.
2. Implementing VBC - Explains the effort, focuses on the need for outcomes, a framework, and talks a little about outcomes and cost.

I’m still unclear about what we are doing, but these articles have helped me understand VBC and a framework of how to think/fxn in a new paradigm. ... I’m looking forward to learning more.”

During this time, we also had frequent check-ins with our coach to help support a positive team dynamic and have a transparent conversation regarding challenges or disagreements on the approach.

Phase B of the first step involved broader stakeholder engagement. During this phase, we first met with our sponsor Sara Holleran through a “discovery” meeting to take a deeper dive into the issue and garner a better understanding of the different key players at Duke that could inform our work. This early meeting also involved some negotiation as a team around potential directions for the project overall. It was during some of our early meetings with Sara that the COVID-19 pandemic began to impact our daily lives and the work of this project. Sara shared with us an important panel discussion on VBC in the COVID era (https://vimeo.com/420817971/e67d2654bc) and helped re-direct our work to highlight that these efforts around VBC are now more important than ever. She involved us in a number of high-level
institutional meetings with PDC leadership on these topics that better steered the direction of our project. Each member of the team met with different key stakeholders (Appendix A) to garner insights on how to formulate our deliverables for this project. These discussions helped us to refine our understanding of this complex topic. As we regrouped as a team to discuss the insights, Mira helped us think about our strategic thinking, overall project management and strategies to think about process improvement.

Step 2: Once we had this baseline understanding and level-setting on the current status of VBC, we felt it was critical to get a sense of perspectives across Duke Health. We performed a baseline needs assessment and gauged Duke Health provider knowledge around VBC. We developed and deployed a 5-question knowledge assessment (Appendix B) of VBC that was designed to take less than 10 minutes to complete. Questions ascertained knowledge around what is meant by VBC, why are we talking about this now, why does it matter to Duke providers and provider needs. The survey was completed by 30 different providers. See appendix for full details of the questions and responses. These perspectives provided our team important data to inform our potential target deliverables. The responses also helped anchor us in the variability of knowledge around VBC as our team itself was becoming more experienced.

Step 3: Defining and developing our deliverables – With these background data and diverse Duke perspectives, we felt prepared as a team to define our deliverables for the project. We initially had a number of different potential ideas, but we collaborated as a team and with our coach to better refine and negotiate the project. We honed the project through multiple iterations to make it useful to the broad group of stakeholders and to make it feasible for our fairly short project period. We kept the different stakeholders involved throughout the process since we felt this would be critical to support future uptake and dissemination. Ultimately, we felt that the most helpful items to develop and share would be as follows:

1) A brief, engaging overview video on VBC. We felt that it was important to educate the broad group of providers across Duke Health on what VBC involved and why we need it.
2) A toolkit for leaders (Chiefs, Chairs) on what information/incentives they need to provide to engage their group (in the form of a PPT or document)
3) A Value-Based Care Starter Grant in order to utilize the expertise of Duke physicians to target new areas for VBC

Step 4: Pivoting to allow us to pass this project off to the next group so they can continue the work.

After working together to define these deliverables, we were in the process of developing the script for our video and had set a date (April 14, 2020) for our recording in the Duke Simulation Center. Unfortunately, due to COVID restrictions this was delayed. Nonetheless, we pivoted to summarize our recommendations and outline next steps below that will support the continued success of this project for the upcoming DCLP team.

Risks and Alternatives

Regardless of the level of interest of the health system or providers, from our research and data collection, it became clear that VBC is coming to healthcare. Upon review of the various resources discussed above, our group determined that provider participation, perception, and buy-in were vital for our institution to successfully navigate the transition from fee for service to value-based care. Provider practice patterns are integral to the provision of VBC and while the institution can help direct decision making to some degree, it will ultimately be up to individual providers to alter current behaviors and choose those that support the success of a VBC model. For these reasons, we believe that it is vital for
the transition to VBC to be provider-driven with a focus on quality of care and clinically relevant outcome measures. In order for this to occur, providers must not only be involved, but be integral in leading the charge towards VBC. If no action is taken to appropriately educate providers on the benefits of VBC, provider buy-in will likely be low and ultimately will affect the institution’s ability to successfully transition to value-based care. Should adoption of VBC principles and practices be delayed, or worse, not undertaken, Duke University Health System would likely face considerable financial risk and loss of market share.

One important consideration when evaluating the risk of educating providers on VBC is that, if done incorrectly, attempts to inform providers may, in fact, work to deteriorate the provider-institution relationship. If education focuses on VBC as a payer and/or employer-driven change only designed to lower costs, then providers may come to see VBC as a disruptor to the patient relationship. Asking providers to question their practice habits could be interpreted as a burdensome mandate as opposed to a change that will enhance their practices and well-being and lead to better quality care for patients. In addition, if the institution does not follow through on providing adequate support to help providers succeed in a VBC environment, then provider perception may become skeptical, or worse, resentful of the transition to VBC.

Education about changes to healthcare is naturally multifaceted as a number of entities will be affected by the transition to VBC. Our group considered a patient-focused toolkit as a method to encourage adoption; the thought being that patient choice in a VBC marketplace would drive provider behavior. While patient understanding and acceptance of the changes associated with VBC are certainly important, our group felt an effective patient education toolkit would be more challenging at best and potentially even less impactful than the education of providers. We also believe that providers who are well educated regarding the potential positive results that VBC will make in their patients’ lives will be in an ideal position to influence patient perception in favor of VBC.

**Recommendation**

The deliverables our team decided on consisted of three parts in total. The first was a Toolkit in the form of a PowerPoint or Word document designed for Chairs or Division Chiefs to help them to better understand what questions to ask and what information to provide to their group (VBC definition, real world examples, financial incentives, etc). This toolkit would enhance engagement surrounding VBC (Appendix C). The second item was an inspirational video, designed to be between 3-5 minutes long that could be shown to broad groups of providers to educate and engage them around VBC. The video would highlight that VBC is not just coming, it is already here, and explain in simple terms what VBC is and what it is not. The video was designed to be engaging but also create a sense of partnership and importance that may be likened to the recent “Why Duke” campaign. A few examples of VBC would be given, including the example of the cardiac catheterization lab bundle and how that has been successful at Duke in improving outcomes and reducing cost. It would highlight the need for VBC now more than ever in the COVID-19 era, as fee-for-service models are more susceptible to financial strain than VBC models when stay-at-home orders and reduced elective procedures limit revenue for the institution. The video would conclude with an inspirational message that we want our physicians and providers to drive where VBC is going as a bottom-up, grassroots movement rather than passively accepting what is dictated by insurance companies and/or administrators. It would finish with information on how to apply for the Value-Based Care Starter Grant, which is the third component of our project. The last deliverable was to start the process of creating a seed grant for novel VBC ideas that could be developed and piloted at Duke. (Appendix D)
We choose these deliverables after meeting with both content matter experts and our sponsor, Sara Holleran, as we agreed that engaging providers was a key to supporting a successful transition to VBC. Our research showed that a significant number of physicians did not know what VBC entailed, or how it could affect them and their patients, and that they are largely disengaged from a proactive approach to VBC. By informing and engaging our physicians and providers, and utilizing their expertise to identify new areas to target for VBC bundles, we aimed to proactively develop pathways that can reduce cost, improve quality and patient satisfaction, and streamline care while reducing inefficiencies.

Next Steps and Key Elements for Success

In some ways, the recent pandemic has highlighted to many providers the critical need for greater partnership between health systems and physicians. While hospitals, physicians, and patients alike may all strive for cost-effective, high quality, and efficient care, our means of accomplishing this goal seem disparate at times. VBC is one potential solution that if implemented successfully with sufficient provider buy-in, could have a very positive impact for all concerned parties. Our workgroup felt there were three critical elements necessary in order to ensure this partnership would be successful:

1. Provider buy-in
2. Local control and provider ability to affect change
3. Health system support and reinvestment

Perhaps the greatest obstacle that has been echoed throughout our work, is provider buy-in. This seemed to us the first and most essential step and hence where we focused our initial efforts. To help assuage provider concerns and fears of VBC, we felt it necessary to assess their current knowledge and then based on those results, design a toolkit to help providers better understand what VBC is and how it meets our common goals of providing higher quality and lower-cost care. Our plan was to provide as our final project both written materials as well as short informative videos to providers which highlight that while VBC may be coming regardless of our individual apprehensions, there was much we could contribute during this organizational time to affect positive change. With a sense of comradery, provider buy-in will be more feasible. With the adjusted timeline, we would encourage next year’s team to continue along the lines of establishing provider buy-in and following through with a finalized toolkit and video product.

Integral to the success of VBC within Duke University Health System is a true sense of partnership between providers and the hospital. Often within a large health system it can feel daunting to create change at the individual level. Conceptual involvement at the provider-level as well as operational participation is critical to ensure that we move forward with a sense of local control and are afforded adequate resources to do so. With sufficient health system support, providers may better appreciate the symbiotic relationship between parties. This comes however, with a commitment on the health system side to make resources available and to reinvest any cost savings and profits back into the work and programs that helped make VBC successful. Based on feedback from current VBC programs at Duke, this commitment has been less clear and the refreshing new approach that we outline herein would be important next steps for those continuing this project forward.

Overall, our group sees VBC as a successful endeavor that could be positive within the Duke University Health System given investment in education and partnership. Mindfulness of the critical components for success and careful consideration of next steps moving forward will help to ensure realization.
Acknowledgements

We would like to acknowledge the support and guidance from both our sponsor (Sara Holleran, MPH) and our coach (Mira Brancu, PhD) for this project. Without their remarkable dedication and commitment to helping our team, we would not have been as productive and would not have learned as much both about VBC but also about team-based project leadership.

In addition, we would like to recognize the contributions from the multi-stakeholder team that provided input and guidance to our team throughout the process as noted in Appendix A. These individuals included Dev Sangvai, Manesh Patel, Schuyler Jones, Michael Bolognesi, Sean Sondej and Jill Engle.

We would also like to recognize the support of Dr. Cary Ward as well as Mr. Kyle Nunn for their leadership, guidance and operational expertise throughout the DCLP.
## APPENDIX A: Stakeholder Engagement Individuals.

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<tr>
<th>Stakeholder</th>
<th>Relevant Expertise and Insights</th>
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<tr>
<td>Dev Sangvai</td>
<td>His efforts leading many of Duke’s VBC efforts informed our project directions; his prior leadership of the DCLP program and insights around the project work helped us refine our approach.</td>
</tr>
<tr>
<td>Manesh Patel and Schuyler Jones</td>
<td>Their work with a coronary intervention bundle with CMS in 2015 helped provide a granular example of successes, challenges and opportunities for future work in VBC.</td>
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<tr>
<td>Michael Bolognesi</td>
<td>Insights around how total joints have been involved with VBC and bundled payments for a couple years now with BCBS, a year for Medicare and are currently looking towards expanding with UHC.</td>
</tr>
<tr>
<td>Sean Sondej and Jill Engle</td>
<td>Through our discussions, we learned about ongoing efforts for VBC in the heart center. Examples included post-op care for CABG patients with multidisciplinary support and seamless patient portals to improve the patient experience, clinical quality and reduce readmissions.</td>
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APPENDIX B: Survey Questions

What is your Department and Title?

What is Value Based Care (VBC)? (If you do not know, you can stop the survey)

Why are we talking about VBC right now?

Why does VBC matter to individual Duke physicians?

How could you start practicing medicine differently in the VBC paradigm?
Objective:

1. Improve outcomes
2. Minimize harms
3. Decrease cost if possible

Emphasis is on patient outcomes:

What are the key metrics in your practice?

Goal: improve quality of care while minimizing side effects (eg poor outcomes, side effects and cost).

When choosing outcomes you may want to consider:

1) Focusing on specific diagnoses, or a set of diagnoses
2) Identifying an outcome that is measurable. Some examples include:
   a) Readmissions
   b) Patient satisfaction
   c) Cost

Real life examples of value based care include:

Radiology: Protocols that reduce unnecessary films and scans lead to less radiation and decreased cost

Antimicrobial Stewardship: Reducing unnecessary antibiotics leads to better patient outcomes, fewer side effects, and decreased cost.

Management of Back pain: Virginia Mason Health Clinic organized a low back pain clinic that lead to patients missing fewer days of work, needing less therapy, and reducing cost while improving the patient experience (https://www.virginiamason.org/spine-clinic)

Chronic disease management/diabetes: Bundled payment models, in which a provider or facility receives a lump sum payment for an episode of care, provide financial incentives for higher quality, lower cost care
Appendix D: Grant template

Think about an inefficient process in your clinical practice that can be improved.

How could it be improved?

Who is the patient population?

Who are the key stakeholders (other departments/disciplines)

What outcomes can you track? (unintended side effects, cost, etc)

What resources will you need to drive change (provider/patient education)