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HealthGroup

# Tracking the Shift From Volume to Value in Healthcare



# Contents

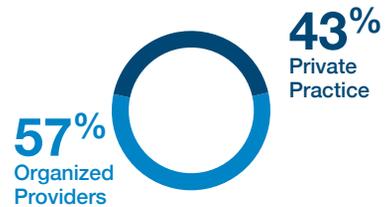
Introduction .....	3
Impact of Value-Based Care .....	4
Recommendations for the Pharmaceutical Industry .....	13
Research Methodology .....	14
About the Authors .....	15
About Capgemini & Omnicom .....	16

## Research study of 866 physicians measured the impact of value-based care on organized providers and implications for the pharmaceutical industry

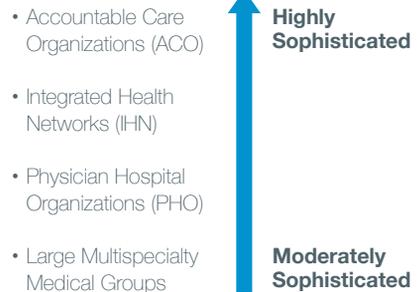
An important response to the increasing cost of healthcare in the US has been the shift of financial risk from the payer to the provider. Today, approximately 60% of physicians are part of an "Organized Provider," employed by Integrated Health Systems, Large Multispecialty Medical Groups, Physician Hospital Organizations, or Accountable Care Organizations. For the first time, nearly two-thirds of these Organized Providers are being reimbursed primarily through Alternative Payment Models (APMs) designed to hold them accountable to quality, cost, and patient outcomes. This is changing the way providers make patient care decisions, with ~40% of providers relying primarily on real-world evidence to inform their treatment approach, ranking it as even more important than clinical trial data.

This report summarizes seminal research conducted to better understand the changes Organized Providers are making in response to the evolving value-based healthcare paradigm as they strive to achieve both their clinical and business goals. The report outlines the impact this has on the role and expectations for the pharmaceutical industry.

### Respondent Composition



### Organized Provider Care Delivery Models



### Real-World Evidence

Real-World Evidence (RWE) is defined as data derived from sources other than randomized clinical trials. The sources of RWE include ongoing safety surveillance, observational studies, registries, claims, and patient-centered outcomes research activities.<sup>1</sup>

<sup>1</sup>21st Century Cures Act, 114th United States Congress, December 2016.

# Impact of Value-based Care

## Value-based care: the new reality

Inefficiencies in the US healthcare system have led to underperformance and inflated costs for all stakeholders. The US spent over \$3 trillion on healthcare in 2015, more than any other developed country. Yet the US has consistently achieved only moderate results on global health measures.<sup>2</sup> With the explosion in data availability and advances in analytic technology, the healthcare industry is now poised to deliver more value for every dollar spent. This movement to value-based care, defined generally as a move away from fee-for-service payments, changes provider reimbursement to a system based on improvements in health outcomes, quality, and costs.

Change has come amidst evolving care delivery models and the emergence of Health Information Technology (HIT), which are providing the infrastructure necessary to shift risk to providers with the goal of controlling spiraling healthcare costs and improving patient outcomes. Consumers, too, are being asked to shoulder increased financial risk in the form of higher out-of-pocket costs. And in some cases the pharmaceutical industry is agreeing to bear some of the financial risk tied to the real-world performance of their products. The importance of addressing the Triple Aim goals of quality of care, patient outcomes, and cost among Organized Providers—the emerging gatekeepers of healthcare—has never been stronger.

### What is the Triple Aim?

Developed by the Institute for Healthcare Improvement, the Triple Aim is an approach to optimizing health system performance via three dimensions:

- 1 Improving the patient experience (including quality and satisfaction)
- 2 Improving the health of populations
- 3 Reducing per capita cost of healthcare



<sup>2</sup>Organisation for Economic Co-operation and Development Health Data 2015.

# Impact of Value-based Care

## Driving the shift: a perfect storm

A number of factors have come together to accelerate the move to value-based care:



**Demographic Trends:** An aging population with associated increases in the prevalence of chronic disease has increased healthcare consumption and costs.



**Legislation:** Compliance with legislation such as the Affordable Care Act (ACA), the Medicare Access and CHIP Reauthorization Act (MACRA), and other quality incentive programs has greatly expanded administrative burdens, making small and solo practices difficult to profitably maintain. This has accelerated the rush of small practices into larger organized provider networks, which centralize administrative burden. Any new healthcare legislation will likely continue to drive Triple AIM initiatives even further.



**Reimbursement:** The Centers for Medicare & Medicaid Services (CMS) has been a leader in tying reimbursement to demonstrated quality and outcomes. Our research shows that nearly two-thirds of Organized Providers are taking on financial risk in the form of alternative payment models such as pay-for-performance contracts or capitated payment systems (Figure 1). For institutions to thrive in this new environment, they must continue to adapt their care delivery models in a way that mitigates this additional risk.

Figure 1

Today, nearly 2/3 of Organized Providers operate under Alternative Payment Models (APMs), a percentage expected to rise with upcoming payment reforms such as the Medicare and CHIP Reauthorization Act (MACRA).



**Q:** Through which payment model is your organization PRIMARILY reimbursed? (N=283)

# Impact of Value-based Care

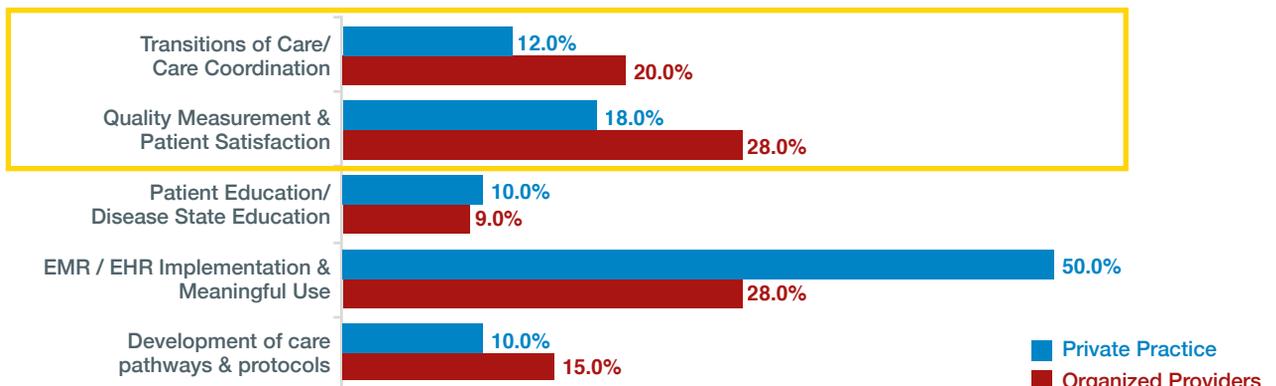
## Organized Provider response to the changing landscape

Moving forward, Organized Providers will prioritize 3 key aspects of continuous care management to successfully achieve outcomes targets:

- 1** Structuring clinical operations around **quality metrics and care coordination**. Our research shows that compared with private practice physicians, Organized Providers are moving beyond Meaningful Use and beginning to leverage HIT systems to address the challenges of measuring and improving quality and patient satisfaction to satisfy the new reimbursement requirements (Figure 2).
- 2** **Improving cost efficiency**, which will be vital for maintaining operational integrity and demonstrating value for the money.
- 3** Furthering **technology integration** with increasingly **sophisticated digital health technologies** to give providers access to comprehensive, real-world data sets and therefore more powerful insight generation. Organized Providers will continue to make investments in their HIT infrastructure so that they are better equipped to respond to payer and patient expectations.

Figure 2

Organized Providers are now moving beyond Meaningful Use (MU) to leverage the capabilities of Electronic Health Records (EHR) systems reporting on quality and coordination of care



**Q:** In which area is your organization/practice facing the biggest challenges today? (N=775)

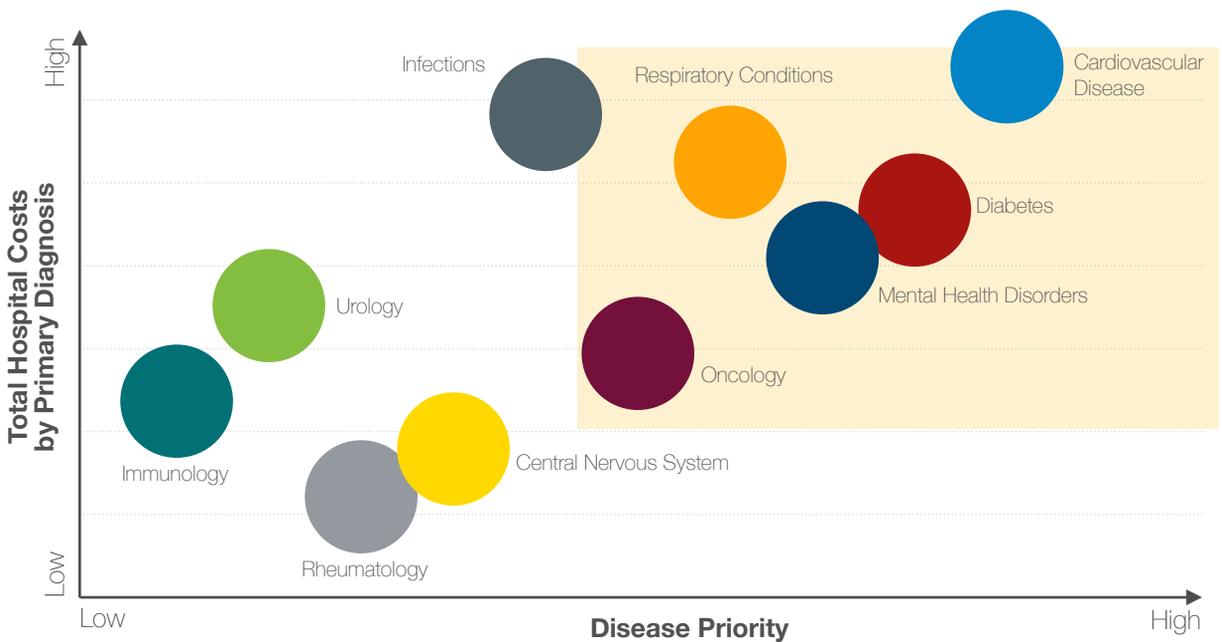
# Impact of Value-based Care

## Population health management takes center stage

Population health management seeks to reduce the burden of illness across a given population, an effort driven by both public and private payers as a means of reducing overall healthcare costs and demonstrating value. Figure 3 below shows a clear correlation between healthcare costs and the disease conditions Organized Providers have identified as priorities for population health strategies going forward.

Figure 3

In addition to Cardiovascular Disease, Diabetes and Respiratory, Mental Health is quickly rising as the next priority for cost-efficiency and quality improvements for Organized Providers



**Q:** Which of these disease states has your organization identified as a future area of focus to control cost/improve quality, that it is not currently a focus today? (N=283)

**Notes:**

Disease Priority reflects relative ranking of disease state priority for cost control and quality improvement, based on survey data. Total Hospital Costs by Primary Diagnosis based on data from the Agency for Healthcare Research & Quality, 2014.

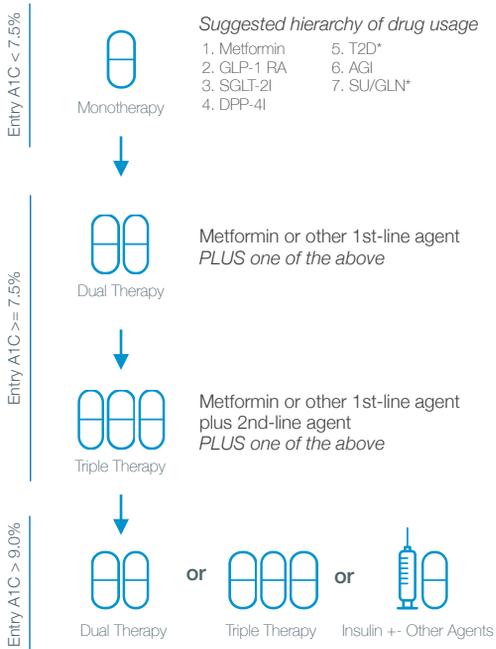
# Impact of Value-based Care

The priority areas identified are mostly chronic, multifactorial diseases that encompass genetic, environmental, and behavioral determinants. For providers, this suggests an opportunity for continued digital integration and quality improvement. Organized Providers are ideally structured to implement interventions and standardize treatment across settings to ensure consistent clinical quality (See "Case Study: Kaiser Permanente Diabetes Pathway"). This includes addressing the lifestyle and behavioral components of disease and wellness.

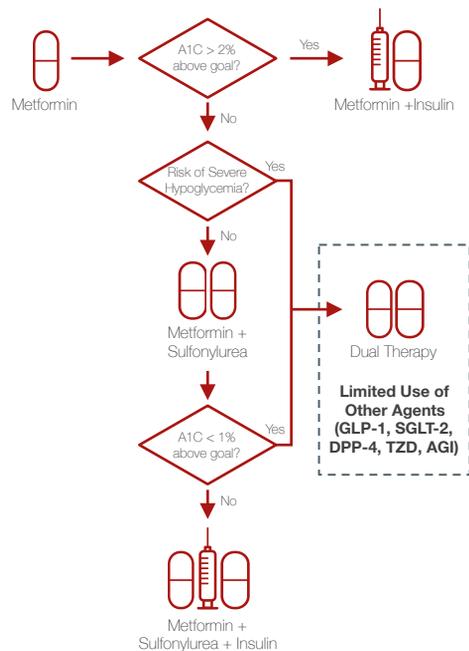
## Case Study: Kaiser Permanente Diabetes Pathway

The case of diabetes care at Kaiser Permanente is a good example of the impact Organized Providers' population health management initiatives can have on the pharmaceutical industry. Kaiser used real-world data to analyze the cost and effectiveness of the various diabetes management products recommended in the American Association of Clinical Endocrinologists guidelines. Based on this data, they concluded that they could streamline the treatment pathway to improve the efficiency and lower costs of their diabetes care, effectively eliminating certain product classes from prescribing decisions. Adherence to this treatment pathway was monitored through the Electronic Health Records (EHR) and Clinical Decision Support (CDS) systems used throughout the Kaiser organization.

### American Association of Clinical Endocrinologists Diabetes Therapy, 2016<sup>3</sup>



### Kaiser Permanente Diabetes Therapy, 2016<sup>4</sup>



\*Use with caution.

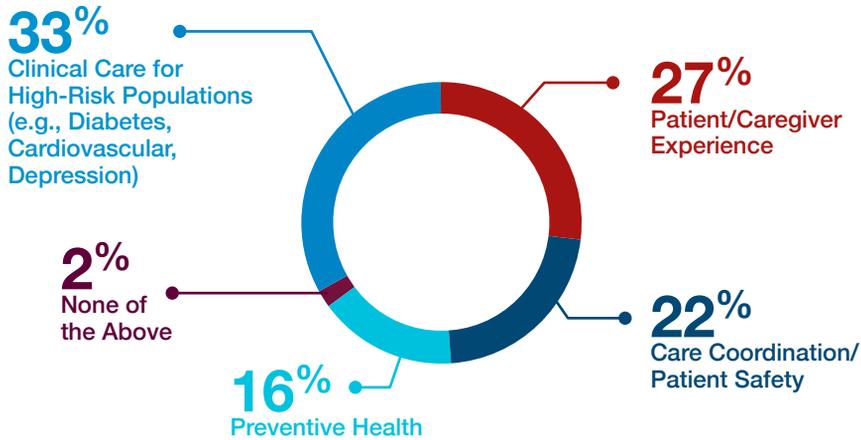
<sup>3</sup>AAACE/ACE Consensus Statement on the Comprehensive Type 2 Diabetes Management Algorithm 2016.

<sup>4</sup>Kaiser Permanente National Clinical Practice Guidelines, Adult Diabetes, January 2016.

# Impact of Value-based Care

Figure 4

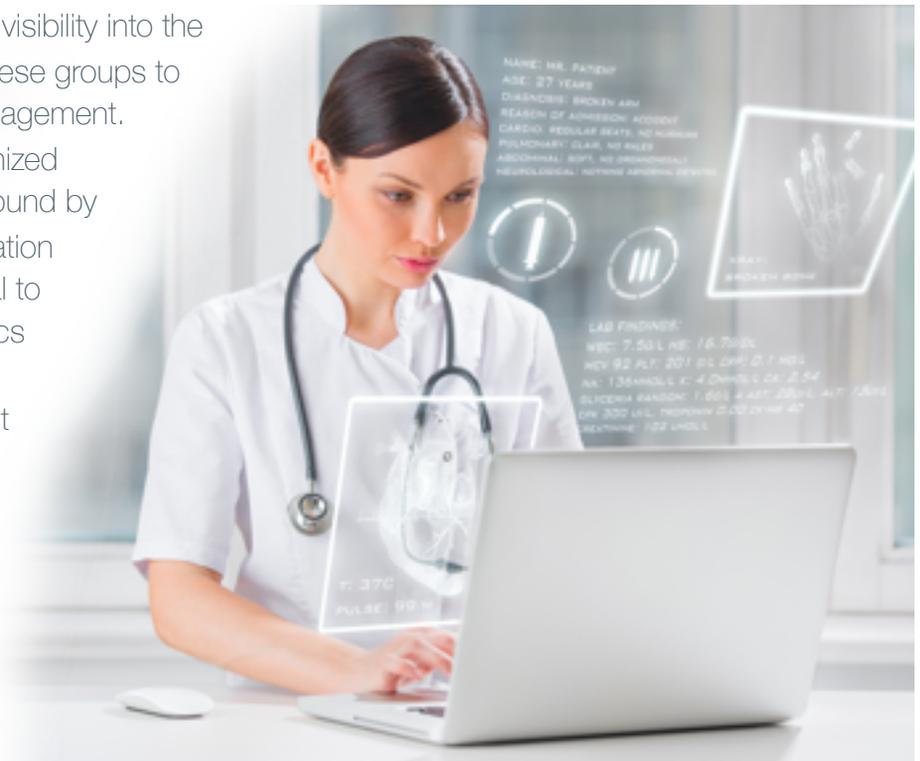
In addition to tracking treatment and costs associated with high-risk patient populations, Organized Providers are also building systems to measure preventive care, patient safety, and patient experience



**Q:** In which category of CMS quality measurement is your organization currently placing the MOST focus? (N=283)

Their size and unprecedented visibility into the entire patient journey allows these groups to excel in population health management.

This capability is vital for Organized Providers, particularly those bound by CMS standards, where population health components are integral to quality and performance metrics (Figure 4). Moving forward, population health management will continue to expand, focusing on additional disease states and creating new quality measurements tied to reimbursement as a key part of achieving the goals of the Triple Aim.



# Impact of Value-based Care

## New ways necessary for the pharmaceutical industry to engage

### Increase in No-See Providers

Traditionally, pharmaceutical organizations relied on their sales representatives to provide relevant information to providers. However, our study shows that 54% of Organized Provider respondents reported restricting sales team access, often due to organization policies. In fact, nearly one-third of Organized Providers block access to sales representatives completely (“no see” policies). Traditional engagement models will have to be adapted to better align with the needs of these customers.

### Preference Shifting to Digital Information Channels

Nearly 50% of Organized Provider respondents reported that digital communication channels were their preferred method of communication, with email and web portals cited in our research as especially valuable (Figure 5). Perhaps unsurprisingly, this preference for digital communication was considerably stronger among Organized Providers as compared to private practice physicians.

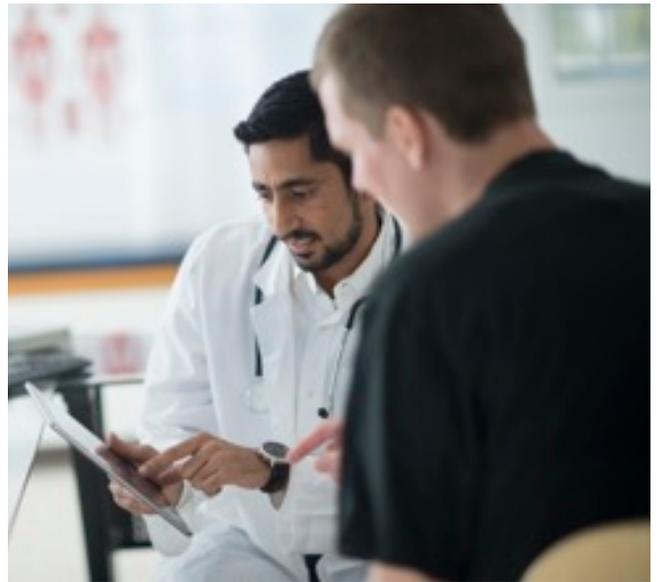
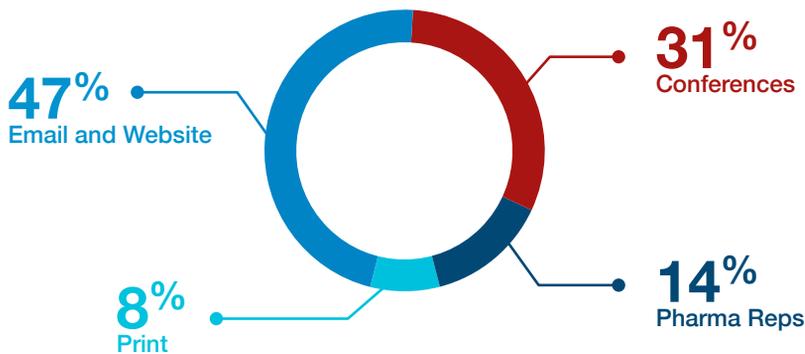


Figure 5



Q: What do you think would be the most ideal environment or structure for pharmaceutical communications with you and your current employer or practice? (N=789)

# Impact of Value-based Care

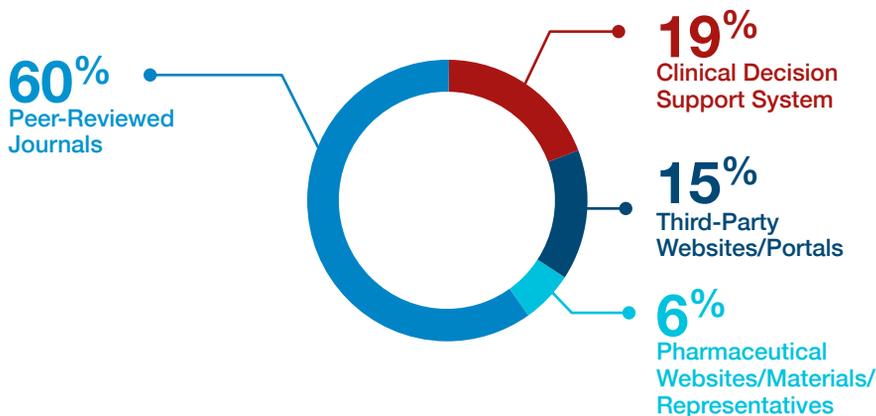
Electronic Health Record (EHR) and Clinical Decision Support (CDS) systems are becoming the fundamental sources of clinical information, particularly among organized providers who are taking on financial risk (Figure 6). Increasingly, pharmaceutical companies will need to understand how to integrate with and augment these HIT systems in order to maintain strong provider engagement. For example, several leading pharmaceutical companies are now developing instruction manuals for updating medication order sets and programming co-pay cards into EHR systems as part of their launch preparations. Currently, the average lead time for a new product to be available in most EHR systems is ~6months after FDA approval, due to the process for a new medication to be updated in drug compendia and subsequently pulled through to the EHR companies and refreshed by the individual provider organization. This last delay in refreshing the EHR at the system level effectively prevents Organized Providers from prescribing the product upon launch. By being proactive in communicating this to Organized Provider customers and creating resources to help update their order sets more efficiently, pharmaceutical companies can alleviate unnecessary barriers to prescribing at launch.

## What is an order set?

An order set is a collection of clinically related orders grouped by purpose, such as prescription orders.

Figure 6

EHR and Clinical Decision Support (CDS) systems represent emerging digital channels that are becoming the primary platforms for healthcare information



**Q:** What source do you most frequently access for information to inform decisions regarding patient care? (N=466)

# Impact of Value-based Care

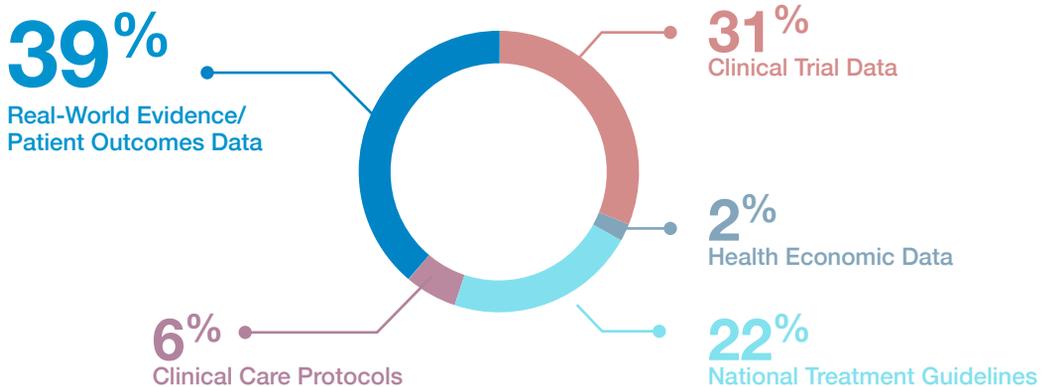
## A Strong Demand for Real-World Evidence

Providers rate real-world evidence (RWE) as the primary basis for treatment decisions, outpacing even clinical trial data (Figure 7). Establishing partnerships with Organized Provider groups with the infrastructure required to generate this data presents a significant opportunity for pharmaceutical companies to develop RWE that supports their brands.

In addition, Organized Providers will be looking for tools and resources from pharmaceutical companies that address different needs than they had in the past and go beyond clinical information and education. In our survey, respondents anticipated relying more on pharmaceutical companies for information on guidelines and quality metrics in the future, a 50% increase from the amount today. Providers also emphasized the need for reimbursement information, the importance of which increased nearly two-fold compared to the value they place on it today.

Figure 7

Organized Providers reported using Real-World Evidence as the most important data to inform treatment decisions



**Q:** Rank, in order of importance, the information that most impacts your treatment decisions? (1=most impactful, 5=least impactful) (N=752)

## The Pharmaceutical Sales Representative Must Evolve

Despite decreasing access, there is still an important role for traditional pharmaceutical representatives' support. While the provider population overall prefers digital channels, individual specialties have unique preferences. For example, endocrinologists continue to favor in-person engagement (34%) and sales representative visits (31%) over digital communication. In these instances, equipping sales reps with high-value information such as RWE and reimbursement support tools can still open doors to provider practices.

# Recommendations for the Pharmaceutical Industry

## Healthcare evolution is at a historic point

Today, efficiency, value, and cost are fundamental considerations impacting every clinical and business decision providers face. Organized Providers are asked to deliver improved clinical outcomes with increasingly limited time, limited resources, and with stricter reimbursement requirements. Providers are feeling the squeeze as never before.

The pharmaceutical industry has a unique opportunity to provide support that is aligned with provider needs by applying these three critical success factors:

### Embrace the Triple Aim



Incorporate the Triple Aim framework into strategy design and decision-making across all functions to better align the business with Organized Provider priorities

Identify how to help customers achieve their performance metrics via RWE and health economics data

Develop value stories that help customers see how optimizing treatment for target patient populations will help them improve quality and outcomes while reducing costs and supporting population health management goals

Align all commercial functions and business processes to support a customer-centric account management approach

### Speak the language of quality and RWE



Develop Real-World Evidence, such as data sets that align with quality and performance goals, in collaboration with your customers

Develop value communication strategies to help the customer understand how a product will help them streamline and improve performance

Initiate partnerships to build and maintain the appropriate RWE databases to support care pathway development and track performance

### Invest in Digital Solutions



Shift promotional resources and budget allocation to optimize digital channels across the care continuum in ways that allow reps to reach and engage providers at more touch points

Create solutions and services that will augment and integrate into EHR and CDS, recognizing that these will be the key sources of clinical decision information going forward

Leverage health technology to facilitate changes in provider workflow that support the brands and achieve the customer's clinical and business goals

# Recommendations for the Pharmaceutical Industry

## Value-based care is here to stay

The drivers pushing Organized Providers to the frontier of healthcare reform are too strong to reverse. As leaders in this new environment, Organized Providers are facing a unique set of challenges in order to demonstrate quality and value to payers and patients.

The pharmaceutical industry has the opportunity to help guide and support customers through this evolving landscape. Fostering closer relationships with Organized Provider customers will ease the transition to value-based care, and prepare pharmaceutical companies for a potential future in which they, too, may be asked to share some of the financial risk as a key partner in US healthcare.

**For more details about this seminal study and information about how Omnicom Health Group and Capgemini Consulting can assist you in achieving your business goals, please contact [volumetoaluestudy@omnicomhealthgroup.com](mailto:volumetoaluestudy@omnicomhealthgroup.com).**

## Research methodology

The research is driven by a partnership between Omnicom Health Group and Capgemini Consulting. Omnicom Health Group is the largest healthcare marketing and communications group in the world. Capgemini Consulting is the global strategy and transformation consulting brand of the Capgemini group specializing in enterprise transformation from innovative strategy to execution. Together, we conducted a survey of 866 US-based physicians, representing 27 specialties across all 50 states, leveraging Omnicom Health Group's proprietary HCP Insights™ database. Respondents were split approximately 50/50 between generalists and specialists. Organized Providers were defined as physicians belonging to any one of 3 groups: Large Multispecialty Medical Groups, Physician Hospital Organizations (PHOs) or Integrated Delivery Networks (IDNs). The study was fielded for two weeks between September and October 2016. In addition, the study results were validated through ten in-depth focus interviews with Organized Providers and discussions with leading pharmaceutical company stakeholders.

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Special thanks to **Jynette DeMarco**, **Maggie Jordan**, **Edie Pargh**, and **Nina Greenberg**

## Capgemini Consulting

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