

# Managing the Critical Transition from Volume to Value

By Diane Shannon, MD, MPH

## In this article...

Experts say value-based health care delivery truly is the wave of the future. Learn what you need to do to get ready to embrace the change.

Health care executives, government leaders, policy experts, and politicians agree that significant changes to our health care system are urgently needed to curtail the growing financial burden of health care costs to individuals, employers, and our society.

This concern is especially critical in light of the aging Baby Boomer population and the historical growth of health care costs in excess of inflation.<sup>1</sup> Economic experts have pointed out that an essential element of reform is removing the incentives that reward greater volume of health care services under the current fee-for-service payment model.<sup>2</sup>

In addition, organizations such as the Joint Commission, the Institute of Medicine, and the Institute for Healthcare Improvement have highlighted the need for improved quality, patient safety, patient-centeredness, and clinical integration in our health care delivery system.<sup>3, 4, 5</sup>

Initiatives associated with the Affordable Care Act (ACA), such as establishing Accountable Care Organizations and the medical home, aim to shift from a volume-based delivery system to one that rewards coordinated care.<sup>6</sup>

Transitioning from a volume-based delivery system to one focused on value, or delivering improved care at greater cost efficiency, will be challenging for providers, health systems, and hospitals, because it requires a fundamental shift in the payment and reward model.

Strong and thoughtful physician leadership is essential for helping provider groups and health care organizations make the shift from volume- to value-based care delivery while remaining economically viable and continuing to provide high-quality health care.

## The meaning of value

Value is a word that has come to hold a number of connotations in health care—in some cases implying a strict focus on cost reduction.



Professor Michael E. Porter, PhD, of Harvard Business School, who has studied the topic extensively, defines value in health care as the health outcomes achieved divided by the total costs for the full cycle of care.<sup>7, 8</sup>

### Porter

“The value concept says that what we really care about is not the individual services that we delivered, but the value we created. The goal is to be as efficient as possible in delivering good health outcomes,” he says. Porter believes that the ideal means for lowering costs is to focus on improving value through better patient outcomes, rather than restricting services or reducing reimbursement.

At Billings Clinic in Montana, value is defined as providing optimal quality at an optimal cost over time, according to Physician-in-Chief Mark Rumans, MD. Citing Donald Berwick’s Triple Aim as a foundation,<sup>9</sup> Rumans notes that, “Value also includes assessing the health of a population, the experience of care, and the total cost of care. It’s a focus on improving the health of an entire population over a period of time.”



### Rumans

John A. Benz, MBA, senior vice president and chief strategic officer at Memorial Health Care Systems in South Florida, emphasizes that, in a volume-based delivery system, hospitals and care providers are paid regardless of outcome.

In a value-based model, they are paid according to the transaction, if they meet minimum quality thresholds, and may also receive incentive payments for exceeding these thresholds.

Mark Hiller, vice president of innovation at Premier, a health care performance improvement alliance of more than 2,500 hospitals and 72,000 other care sites, emphasizes that



**Hiller**

in a value-based delivery model, providing more services does not automatically result in higher levels of compensation or reimbursement to

physicians, physician groups, hospitals, or other providers.

For this reason, the value model focuses attention on developing the best plan for service delivery for the patient. In short, at the foundation of the value-based delivery system is a model in which reimbursement and payment are driven by the outcomes achieved by providing a set of services that varies depending on the patient's condition, rather than the number of services provided.

## The stakes

The potential consequences of poorly managing the transition to value-based delivery—or of not making the transition at all—could be dire. Health care experts seem to agree that change in the payment for health care services is coming—a when, not if, scenario.<sup>10, 11</sup>

According to Porter, payers are going to begin to think differently about how they contract with providers. “The payer community is now deeply concerned about their future and will not be signing on every hospital system just because they did in the past. Ultimately, I believe they will also not simply choose the lowest-cost providers. Rather, they are going to be increasingly seeking out providers who are moving in the direction of providing value for patients.”

Porter believes that clinging to the old model of volume-based, fee-for-service reimbursement is not a feasible option. “There is no defense for the existing model. We’ve been trying to reform it for 20 years. Now, for many reasons, the status quo is no longer going to be viable. The stakes are simply that high.”



**Benz**

Benz from Memorial Health Care Systems agrees. He believes that physician groups that resist the shift to value-based care will

see their fee structure reduced and eventually be dropped from payer panels. Hospitals that avoid the shift will lose their status as hospitals of choice, because of quality and price sensitivity.

Payers will simply skip over the entities that fail to make the change to value-based care. The end result for these organizations, according to Benz, is not pretty: “They will become dinosaurs and either be bought up or closed. There is no refuge.”



**Schneider**

Going out of business could occur with any financial model if it is not carefully managed, points out Katherine A. Schneider, MD, vice president for health engagement at AtlantiCare in New Jersey. But in this case, the risk of doing nothing is as significant as the risk of managing a model poorly.

Schneider believes that physician groups, hospitals, and health systems have no other viable choice but to embrace this shift. “Even if an organization has been really successful in a volume-based system, they have to let go of that game. We’re past the breaking point now for our communities, and the current system is just not sustainable. We have to make this shift work because the alternative is a continuous downward pressure on price. If we stick with fee-for-service, it will be less fee for our service. Health care organizations need to remain financially viable.”

## The role of physician leaders

Physician leaders are invaluable to a successful transition to value-

based care delivery for two primary reasons.

- First, physician leaders are uniquely qualified to remember the ultimate accountability for the individual patient.

Schneider sees the transition to value-based care delivery as a once-in-a-lifetime chance to build a patient-centered system. “There are many stakeholders in this transition—physicians, hospitals, the government, employers, insurance companies—but the most important one by far, if we’re going to do it successfully, is the patient. It comes back to our oath of professionalism, about putting the patient first.”

In recent months, she has observed several physician leaders exhibit this unique focus. “In all the conversations that I’ve heard on the topic of accountable care and other aspects of reform, when I hear someone talking about putting the patient back in the middle, it’s either a physician executive who is working in a delivery system or a consumer advocate.”

- Second, because they have a foot in both the clinical and administrative worlds, physician leaders are uniquely qualified to understand the goals, values, and pain points of both.

As Schneider puts it, “Physician executives are in a key role in that they can understand physicians’ perspective, such as the desire for very simple administrative rules, as well as hospital administration’s perspective.”

Physician leaders are uniquely positioned to engage physicians and encourage their behavior to be in alignment with the goals of a value-based system. According to Benz, they can pull in clinicians who might otherwise remain rooted in the fee-for-service mindset.

“Physician leaders need to understand how to connect all the dots, and bring along those who are practicing—who are probably less business-oriented—into the business in a safe manner, and lead them to create a value that nobody else does. They are the change masters.” Porter agrees that strong leadership is critical. In his research he has found that clear, decisive leaders are a common characteristic of the organizations that have made the greatest progress toward value-based care delivery. He believes that physician executives can help navigate the multifaceted transformation by leading the discussion about physician payment and fostering better partnerships between physicians and hospitals.

## Essential knowledge

Physician executives must understand some essential information about the transition from a volume-based to value-based delivery model. First, the shift requires a fundamental transformation in thinking and approach. It involves a new focus on outcomes, care across the continuum, and population health.

It requires beginning to view operational activities, strategic planning, and financial projections through the lens of value. According to Rumans, this involves “Looking at everything with a value perspective and focusing on providing optimal quality at optimal cost over time.”

Porter emphasizes that the change in thinking naturally leads to a change in priorities. “If you think about cost reduction, you tend to want to withdraw or withhold services. If you’re thinking about value, you think very differently. You might want to spend more time and energy on certain services—often those that are not well-reimbursed or reimbursed at all under the current system—in order to improve the overall value equation. It is a very different mindset, and it requires a complex

and comprehensive rethinking by health care leaders.”

Schneider asserts that now more than ever before, leaders must focus on efficiency in delivering quality care by factoring value and the cost of care into almost every aspect of their decision making.

She offers the example of interventional cardiology services. At the present time, these services are a large revenue generator for many hospitals. Under a value-based delivery system, this may not hold true. “The question shifts from ‘How do we grow this service as much as we can?’ to ‘How do we make sure we’re growing the service appropriately to meet our community’s needs?’”

The transition also involves a shift from considering silo service lines to crafting multidisciplinary care across the entire care episode that will result in better patient outcomes.

Porter emphasizes the importance of collaboration in the new model of care. “That model of each individual provider and each individual specialty providing their individual service and seeing that as the end of their job will need to give way to providers being part of integrated or multidisciplinary teams that accept collective responsibility for the broader care cycle and the outcomes achieved—not just responsibility for their particular portion of that care cycle.”

Given the breadth of change involved, the transition to value-based care requires an underlying culture shift. Not only must participants remove the silos between traditional service lines and either join or support multidisciplinary teams, but physicians must forge cooperative partnerships with hospitals and health systems.

As Benz points out, “The hospital doesn’t create an order, only the physician does. The physician doesn’t have the infrastructure that the hospital has. The two must work

together to wring out duplication and excess cost from the system without sacrificing the quality of care.”

Otherwise, the venture is unlikely to succeed. “I don’t see how any element in the mix—and by that I mean physicians and hospitals—could move individually and be successful,” Benz says.

Secondly, physician leaders need to recognize that it is, in fact, a transition. As Rumans explains it, “We are still in the fee-for-service environment, which continues to reward volume. The transition to value will come in stages, because not every organization is going to make the move at the same time. Some payers or employers may want to move faster than others.”

A key factor that physician leaders must understand is that the transition cannot occur instantaneously. According to Hiller, “Some providers will have feet in both camps for a while, responding to two inherently different incentive systems. Leaders will need to understand this struggle.”

The transition requires attention to and reorganization of a whole host of organizational elements, according to Benz, including care delivery, financing and financial risk, governance, connectivity and information technology, as well as the availability of capital for infrastructure, staffing, and business office functions.

Pacing the move toward a value-based system is critical to success. According to Hiller, an organization that makes the move too quickly will experience financial stress as its fee-for-service revenue declines due to fewer admissions, readmissions, and ED visits, and lower imaging and surgical volume while it is in the midst of investing resources into preventive care and the medical home.

An organization that moves too slowly is at risk as well. Hiller hypothesizes that latecomers may find it more difficult to enter into

relationships with payers and employers that the first movers will enjoy.

Hiller believes that the “correct” pace will depend on the local market environment (i.e., the degree to which local organizations have already experimented with value-based models or moved away from fee-for-service reimbursement models), the speed at which the Centers for Medicare and Medicaid Services (CMS) institutes changes in Medicare reimbursement, and the degree to which state governments turn toward a value-based model to relieve their health care-related budgetary shortfalls. The correct pace also will depend on the degree to which commercial payers and employers lead or follow CMS.

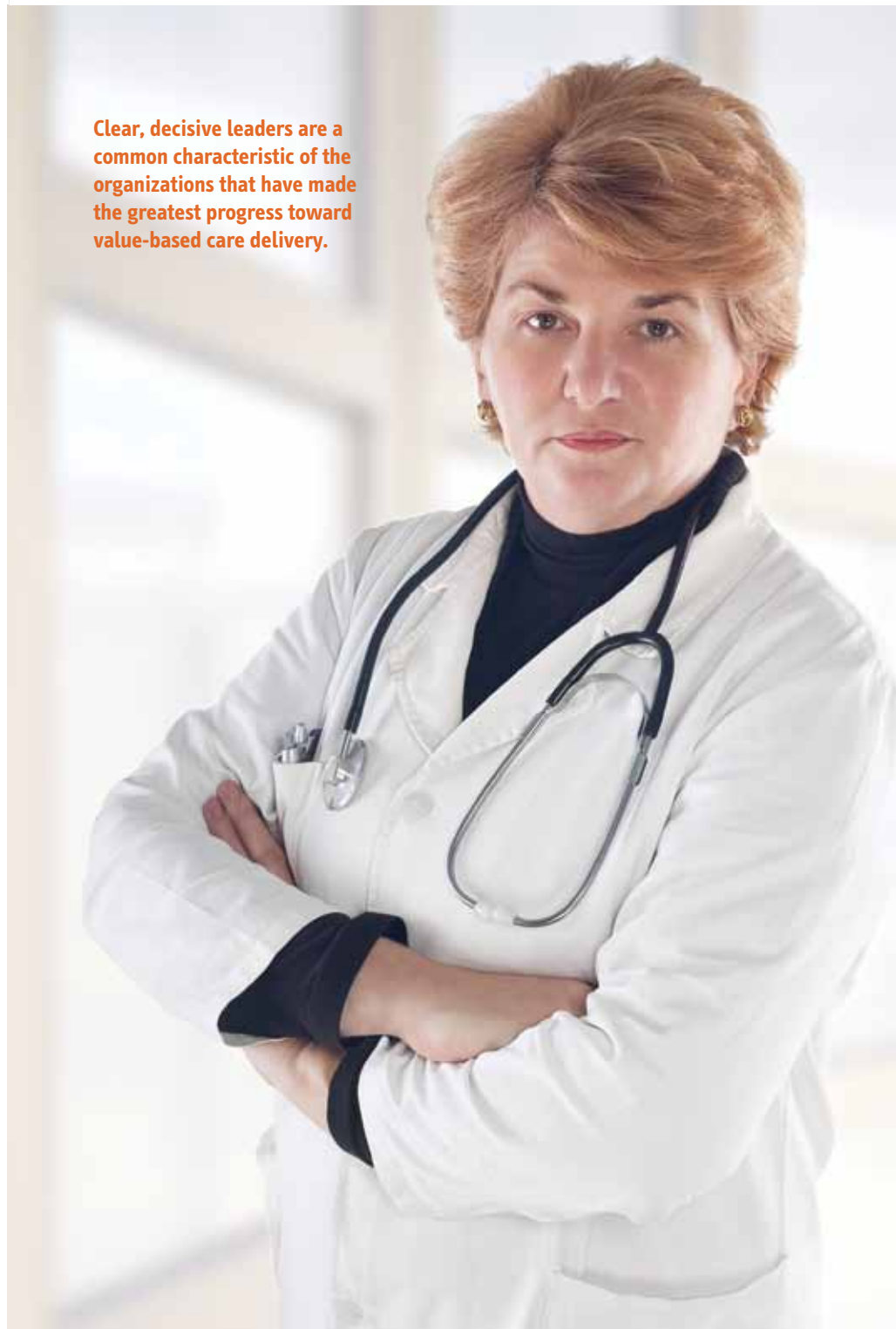
According to Schneider, organizational leaders should first ensure they are applying an effective business model to maximize cost management under their current reimbursement scheme.

Their next step, she says, is to shift some portion of reimbursement or revenue to the value-based model and build that business, rather than trying to build the value-based business while remaining entirely on a volume-based reimbursement system. “There are already good business models out there that give us a basis for managing some aspects of this transition.”



# Action Steps Toward Value-based Care Delivery

**Clear, decisive leaders are a common characteristic of the organizations that have made the greatest progress toward value-based care delivery.**



**Physician leaders can take several action steps to help their organization make a successful transition to value-based care delivery.**

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## **Educate yourself and your colleagues**

Physician leaders can begin to build organizational awareness about value-based care delivery. They can educate peers and front-line physicians about the value-based mindset, concepts, and tools. They can help their peers appreciate the strengths of the value-based business model.

As Rumans points out, by moving to new care models, such as the medical home, an organization can achieve higher quality care, greater patient and staff satisfaction, and cost efficiency. The growth strategy of this business model is achieving lower costs on a per patient basis for higher quality care, not through greater volume of procedures for the same number of patients.

The organization can grow through adding patients who are attracted to the organization by greater quality and patient-centeredness or whose health plans are attracted by the cost efficiency. Helping physicians understand this strength can foster their engagement in the new model.

## **Embrace new metrics**

Effective implementation of a value-based delivery model requires the use of cost and outcome metrics that have not been widely used to date. According to Porter, costs have been considered in silos, assessing, for example, the costs associated with the outpatient visit.

A value-based approach requires leaders to assess costs for the entire cycle of care, which necessitates a new accounting system where fixed costs are allocated to reflect the actual use of resources by individual patients.

Physician leaders need to ensure that their organization has identified the correct metrics to measure and is committed to tracking and distributing the resulting data. Schneider envisions that the “scorecard of the future” will include quality metrics for both inpatient and outpatient services, utilization metrics, such as ER visits per 1,000, and patient experience measurements, such as the degree to which patients are able to access the care they need over the previous 12 months.

Porter believes that value should be measured by assessing costs over the entire cycle of care and by assessing outcomes, using a three-tiered hierarchy that includes the health status achieved or retained, the impact of the care process on the patient, and the sustainability of health.<sup>7</sup>

To manage a population of patients effectively, physicians and nursing staff on the frontlines of care will need easy access to quality, cost, and clinical outcomes data. Physician leaders can be instrumental in ensuring the availability and effective use of these data.

## **Forecast the financials**

Physician executives can lead the charge toward value-based care delivery by accessing and applying a financial modeling system to forecast the implications of the transition. They can use these models to educate other physician leaders, physicians, and members of their board about the financial implications of the transition from fee-for-service reimbursement.

They can use more sophisticated models to both educate and forecast. Detailed models will allow leaders to consider a variety of potential scenarios based on local market dynamics, the current status of the evolution toward value-based care delivery, and other factors.

For example, Hiller, working with others, has built a model for

Premier member hospitals that uses data such as projected utilization (e.g., admissions per 1,000, outpatient visits per 1,000, specialty visits per 1,000, anticipated population growth, and growth of different cohorts within the population), reimbursement rates, degree of financial risk, type of shared savings model, and other factors to estimate financials and resource needs, down to the level of physician staffing levels.

Leaders can vary the independent variables, such as time to shift the organization to value-based care delivery, and get a snapshot of the effects on the entire organization.

## **Pace yourself and celebrate success**

To help their organizations navigate a safe course to a value-based delivery system, physician executives should recognize that the process does occur over night. Porter advises leaders to see the transition as a multi-year project. “I think this transition needs to be viewed as a sequence rather than an edict for change overnight.”

As Rumans puts it, “You have to be willing to hold your breath and sustain things over a period of time.”

Porter recommends that leaders identify the pockets within their organizations in which some degree of shift toward value has already occurred and celebrate these inroads, by encouraging and supporting the champions and staff that crafted the shift. These pockets may be units in which outcomes are routinely measured or in which bundled pricing is already in place.

By focusing on these innovators, leaders can engender enthusiasm among others who might be interested in similar moves. According to Porter, leaders are more likely to succeed with this approach than with trying to coerce those who are less willing to embrace change.

## Anticipating change

Change is coming. Likely this change will involve a shift from a volume-based reimbursement model to one that rewards value. The transition will be a challenging one, and careful pacing of the shift will likely spell the difference between financial viability and failure.

As Schneider colorfully describes it, “We finally have lifted up the Band-Aid and now we’re looking at this big festering wound. We’re arguing over what to do with it. ‘Debride this, graft that, give this drug, give that drug.’ But if we can’t make this work, the next step is going to be amputation—a totally different world within the next five to 10 years. Price regulation, single-payer system, the whole thing.”

Making a successful switch to a value-based system has wide-ranging impact—for individual health care organizations and for our health care system as a whole. Physician leaders play an essential role in the successful navigation of this critical transition.

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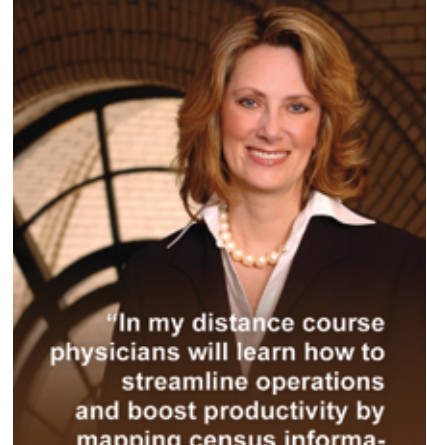


**Diane W. Shannon, MD, MPH**, is a freelance writer who specializes in topics related to performance improvement in health care.

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