Voices on Value

In the Voices on Value series, AHA will highlight the viewpoints of independent experts in the health care field on issues related to affordability, value, and heath care cost. As such, opinions expressed by the authors do not necessarily reflect the policy of the American Hospital Association.

What Is Value-Based Health Care?

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What is Value in Health Care?

Health care costs, over the past half-century, have increased from 6 percent of GDP to 18 percent. During this time, policy makers and health care executives have tried many improvement approaches to stem the increase – adherence to evidence-based medicine, consumerism, lean, quality, safety, checklists, malpractice reform, eliminating fraud – but none has slowed the escalation in costs. To create sustainable change, we need a clear overall objective for health care reform to align all the improvement attempts by the sector's various stakeholders. That objective, referred to as Value-Based Health Care or VBHC, should be to improve the outcomes experienced by patients at lower total costs to society.[1]

Providers, striving to become a leader in VBHC delivery, follow six fundamental practices, called the Value Agenda:

1. Deploy multi-disciplinary care teams, which we refer to as Integrated Practice Units (IPUs), to deliver care at the condition level
2. Measure Outcomes and Costs at the condition level over complete cycles of care
3. Offer (or accept) Bundled Payments for complete care of a patient's medical condition
4. Integrate care among multiple delivery sites within a region
5. Expand geographically
6. Deploy an integrated information technology platform

Many providers are already underway with the Value Agenda. Launched in 2013, Oak Street Health (OSH) uses a multidisciplinary team to deliver care for the poor elderly Medicare population around several Midwestern and East Coast cities. Its integrated and comprehensive care, delivered at easily accessible and friendly storefront clinics, has dramatically reduced the incidence of hospitalizations and lowered the total cost of care for this high-risk population. The Cleveland Clinic made "Patients First" its explicit goal and recognized every employee as a caregiver. It reorganized departments into medical condition-centered units, such as cardiac care and neurological care, and publicly reports its patient outcomes at each unit. The shift to integrated care units and public accountability for outcomes has led to increased patient volumes; same-day appointments; regional integration so that less complex cases can be treated in more convenient and lower-cost community hospitals; and new opportunities for geographical expansion. Hoag Orthopedic Institute, a specialty for-profit orthopedic hospital in Irvine, CA, measures and *publicly reports* its clinical and patient-reported outcomes. It introduced time-driven activity-based costing to measure and improve the total cost of care, including care delivered after discharge. Accurate costs gave Hoag Orthopedic the confidence to offer bundled payments through health plans, employers, and third-party-agents (TPAs).

Nationally recognized as a center of excellence for orthopedic procedures, Hoag Orthopedic has ranked as the top provider of knee and hip replacements in California for six consecutive years.

In the remainder of this article, we briefly describe the six Value Agenda practices. We will provide greater detail for the first three topics in subsequent articles in this series, along with best practice examples.

1. Integrated Practice Units

Providers should structure their care delivery around patients and their needs. Value cannot be created or delivered at the level of a hospital, a care site, a specialty department, a specific intervention, or a population. Organizing care around the patient's condition enables clinical teams, along with specialists in nutrition, behavioral modification, social services, physiotherapy, pharmacy, and post-acute care, to collaborate in treating the patient.

An IPU brings together a multidisciplinary team, including both clinical and nonclinical personnel, that is expert in treating a specific condition and capable of managing the patient's care across the condition's care cycle. IPU members are typically co-located, enabling a patient to see all relevant personnel in a single visit. The IPU uses a standardized technology platform to measure outcomes and costs for all individual patients. The data inform IPU team discussions about patients, treatment processes, and results.

An IPU helps to attract volume for the condition, which creates a positive feedback loop as the increased volume drives improvement in outcomes and cost that, in turn, attracts additional volume. From the patient's perspective, the IPU's multi-disciplinary team offers more convenient and holistic treatments that address clinical as well as social and behavioral determinants of health. Individual team members of an IPU think beyond their specific, discrete intervention to how their contributions lead to better patient outcomes and lower total costs.

Several leading institutions use IPUs to deliver better patient care including the Texas Children's Hospital's Congenital Heart Center, MD Anderson Cancer Center's 11 focused units (such as the Head and Neck Center and Breast Cancer Center), Kaiser Permanente Colorado's Primary Care IPU for treating the frail and elderly, and Medtronic's Diabeter™ and NOK clinics in the Netherlands for treating Type-1 diabetes and morbid obesity, respectively. We will describe these IPUs in more detail in the next article.

2. Measure Outcomes and Costs

Comprehensive measurement of outcomes is the single most impactful way to drive improvement. Tracking and improving performance are the hallmarks of successful organizations in any industry, and health care should not be different.

Health care outcomes are multidimensional to reflect clinical and functional outcomes for the condition as well as patient-reported outcomes about improvements in their quality of life and ability to perform normal activities. Outcome measurement should be risk-adjusted to reflect patient risk factors and initial conditions. Eventually, as more organizations track and measure outcomes, the health system will become more transparent and accessible for patients. Providers, such as Hoag Orthopedic, that consistently produce and report superior outcomes will be rewarded with increased market share.

Much of the recent discussion on outcomes has focused on quality, yet outcomes and quality are not the same. Quality has traditionally been measured by broad population-level metrics, like patient satisfaction, process compliance to evidence-based guidelines and checklists, and aggregate metrics like reductions

in safety incidents, complications, and readmissions.[2] Quality measures are important, but they are insufficient, by themselves, to drive transformational changes in care delivery. A focus on systematically measuring condition-specific outcomes that matter for patients spurs insights and innovations into better treatment pathways.

By focusing on clinical outcomes and Patient Reported Outcome Measures (PROMs), such as the Hip Disability and Osteoarthritis Outcome Score (HOOS) and the Knee Injury and Osteoarthritis Outcome Score (KOOS), Hoag Orthopedic saw its complication rates drop to the lowest 3 percent and readmissions drop to the lowest 2 percent among national orthopedic hospitals.[3] It used these results to renegotiate contracts with commercial payers.[4]

VBHC also requires accurate measurement of the costs of all the resources used to treat an individual patient over the full cycle of care. Most clinical cost-accounting systems, however, use top-down, inaccurate allocations of costs to departments and patient treatments. The allocations, based on charges or Relative Value Units (RVUs), are neither informative nor actionable for clinical leaders. Understanding actual resource costs at the patient's condition-level informs decision-making, process improvements, resource allocation, and bundled-payment contracting. Resources include all clinical and administrative personnel; supplies, devices, and drugs; ancillary services, such as laboratory, pathology, and imaging; and equipment and space.

Time-driven activity-based costing (TDABC) is the preferred method for measuring the costs of personnel and equipment. TDABC assigns costs based on the quantity of time patients spend with each person and equipment type over the course of the treatment's care cycle. Using TDABC sheds light on the cost of both billable and non-billable activities, and leads to better decisions about patient and family education, task downshifting, process improvements, and resource capacity and use. It enables organizations to benchmark costs across similar units treating the same condition and then to transfer best practices and eliminate redundant and non-value-added process steps.

3. Bundled Payments

Changing how we pay for care is the strongest lever to remedy the bad incentives caused by fee-for-service payments. Bundled payments are the preferred VBHC payment method because they directly incentivize achieving better patient outcomes at lower cost. A VBHC bundle makes a single payment to cover all the care required to treat a patient's medical condition over the care cycle (or a time-based payment ($/month) for treating a chronic condition or population segment). The payment is contingent on achieving good condition-specific outcomes, including care guarantees, and should be risk adjusted to motivate treating older and sicker patients with that condition. The bundled payment price should be set to provide a fair margin when the provider delivers effective and efficient care. Under a bundled payment contract, clinical teams have the freedom and accountability to choose the mix of resources and services that contribute most to good patient outcomes.

In the U.S., the Centers for Medicare & Medicaid Services has been a key driver of bundled payments through its Bundled Payments for Care Improvement and Comprehensive Care for Joint Replacement programs. Many commercial health plans now offer bundles as well, and large employers, such as Walmart, Lowe's, Boeing, GE, and The Washington State Health Care Authority have bundled payment contracts with Centers of Excellence, including Virginia Mason, Mayo Clinic, Cleveland Clinic and Geisinger.

Other Components of the Value Agenda

Component 4 in the Value Agenda requires health care systems to integrate care delivery in their region so that patients are treated at the appropriate care site. For example, primary care and care for simple conditions should be delivered in low-cost, convenient clinics and community hospitals, while complex care is delivered only by IPUs located in one or two of the region's tertiary hospitals. Component 5 encourages hospitals to expand their high-value care regionally and nationally, perhaps with satellite and affiliate relationships, as Cleveland Clinic, Mayo Clinic, and MD Anderson are already doing. This would enable patients to benefit from better outcomes and society to benefit from the lower total costs of excellent caregiving organizations. Component 6 is to build a fully integrated and interoperable IT platform that is easy for physicians to use as an electronic health record, facilitates consistent measurement of outcomes and costs, and can readily accommodate bundled payment contracts. More information on Components 4-6 of the Value Agenda can be found in this *Harvard Business Review article*.

Transitioning to Value

Widespread adoption of VBHC will facilitate healthy competition among providers to determine who can deliver the best outcomes and the lowest cost for a patient's medical condition. This is exactly how competition drives better value for consumers in every other sector. Providers unable to offer good outcomes or lower their costs for a given condition may need to withdraw from treating that condition, and to focus on treating those conditions where they are both effective and efficient. As more patients are treated by high-outcome, low-cost providers, and fewer patients by poor-outcome, high-cost providers, simple arithmetic guarantees that average outcomes will increase across the system and average costs will decline. Over time, this positive competition will finally deliver a more effective, lower-cost US health care system.

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Sources

1. Value-Based Health Care was initially proposed in M.E. Porter and E. Teisberg *Redefining Health Care*.
2. Porter, Michael E., and Robert S. Kaplan. *"How to Pay for Health Care."* Harvard Business Review 94, nos. 7-8 (July–August 2016): 88–100.
3. Kaplan, Robert S., and Jonathan Warsh. *"Hoag Orthopedic Institute."* Harvard Business School Case 115-023, August 2015. (Revised August 2015.)
4. Ibid.