

Turning Value-Based Health Care into a Real Business Model

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The shift from volume-based to value-based health care is inevitable. Although that trend is happening slowly in some communities, payers are increasingly basing reimbursements on the quality of care provided, not just the number and type of procedures. But because most providers' business models still depend on fee-for-service revenues, reducing volume (and increasing value) cuts into short-term profits. How, then, are innovative providers redesigning care so that, despite financial pain in the short term, they achieve long-range success?

Let's start with four examples from the front lines of care and then step back to see what deeper strategic advantages all of them have in common.

At Intermountain Medical Group clinics, mental health care is integrated with primary care as a default practice, first piloted 15 years ago. All primary care patients undergo mental and behavioral health screening, and they get appropriate follow-up with counselors, often at the same location. The clinicians collaborate in the same way for all patients, whether or not Intermountain's health plan is the insurer. As a result, patients are receiving coordinated behavioral care, and their outcomes are improving. Costs per member are now \$22 higher up front but are also \$115 lower overall annually, because of reductions in ER visits and other care. In the current fee-for-service environment, Intermountain obtains those long-term savings for the minority of patients for whom it is the payer, but other payers reap the rewards for most patients.

At Mayo Clinic, surgeons who perform lumpectomies or partial mastectomies for breast cancer work during the operation with the Frozen Section Pathology Lab to determine whether all the cancer has been

removed. Such microscopic analysis of frozen-tissue samples can take 24 hours or more at some hospitals, but Mayo achieves it in, say, 20 minutes while the surgery is in process. Yes, 20 minutes is valuable extra time in an operating room while the surgeon and staff wait for pathology findings. But Mayo doesn't do it just to get results to a patient 23 hours sooner. The main benefit is the on-the-spot chance to extend the surgical excision, if needed, to remove all evidence of cancer. That approach eliminates the need for repeat lumpectomy in about 96% of patients. In a study of five years of lumpectomy data, the 30-day reoperation rate was 3.6% at Mayo in Rochester, Minnesota, compared with 13.2% nationally. The result: Mayo's costs for surgery are higher in the short term, and it earns less revenue from follow-up operations. But it reduces overall medical costs, and the patient gets peace of mind more quickly.

The American College of Radiology (ACR), in 1993, developed clinical practice guidelines for radiologic services. Some of the task force leaders came from Boston's Brigham and Women's Hospital, which subsequently introduced its own internal radiology prior-authorization program — for all patients, regardless of payer. The hospital's computerized order-entry system now compares imaging requests with the patient's medical record, allowing physicians to check for prior imaging and to see whether the new request jibes with current ACR guidelines. The system improves patient safety and outcomes, but it slows down and irritates physicians who are trying to order a test. Revenue has also taken a hit as so-called "low-value" tests have declined (for instance, CT chest scans for pulmonary embolism fell by 20%). In addition, patients whose images were imported from other hospitals had a 17% lower rate of new diagnostic imaging, compared with patients

whose prior images could not be obtained. The result: more-appropriate use of radiology tests for all patients, but crankier physicians and forgone revenue. Insurance companies were the major financial beneficiaries for almost all patients.

And Intermountain Healthcare initiated a care-process model for febrile infants in 2008, including guidelines for the use of physical exams, lab tests, antibiotics, and discharge criteria. As a consequence, more infants with urinary tract infections or viral illnesses were identified and appropriately treated, and fewer infants at low risk for serious bacterial infections received antibiotics unnecessarily. Infant outcomes improved, hospital stays shortened with no increase in readmissions, and overall costs declined. Intermountain made a major investment even though one of the results was lower patient revenue.

Acts of Strategy

In all four examples above, the organizations' short-term financial hits were real and painful. Nevertheless, we don't consider these efforts to be acts of charity but acts of strategy. What specific strategic elements do they share?

First, in each example, the provider organization used process improvements to boost quality of care for patients: better outcomes, an enhanced care experience, lower anxiety, less wasted time, and fewer health risks. When the results became clear, each effort also fostered pride and teamwork, thereby reducing employee turnover.

Second, the organizations decided that improving value was more important than short-term fee-for-service profit. They made investments — and often disrupted the habits of their staff — because they recognized that a business plan based on value was the right kind for their patients.

Third, they decided not to game the system by targeting only patients in contracts that would yield financial rewards. Instead, they understood that care redesign had to be of value for all patients, or it wouldn't happen reliably for any. They traded losses in some contracts for potential defection of some

patients to other providers, greater professional pride, and a forward-looking strategy.

In short, we see a compelling business case for acting now to achieve value-based care without worrying about when the market will make the shift. Provider organizations that are leading the way cite the following reasons for their strategies:

1. Sustainability. Innovative providers aim to compete for and attract more customers with lower prices and higher-quality care and services. As value-based payments gradually replace the fee-for-service model, providers that have not adapted will be left behind.

2. Experience in managing risk. Providers who pursue value-based care as a strategy gain expertise in managing the risk of caring for a population under a prepaid budget. This includes recognizing and managing the full continuum of care, focusing on both prevention and intervention, and using evidence-based care practices to ensure appropriate utilization. Organizations that start sooner will be better positioned for success.

3. Relationship building. Learning to collaborate with stakeholder groups takes time. Health systems are seeking closer alignment with physicians and other staff (whether or not they employ them) who can help to achieve higher value in an evolving marketplace. Relationships also must be cultivated with social service agencies, government, and other provider organizations to address the complex medical and social needs of underserved populations, which often incur the highest costs.

4. Lack of alternatives. A business that delivers health care that patients don't need is pursuing a poor strategy. Providing relatively affordable, high-quality care is much less likely to fail as a strategy, not just with respect to the bottom line but also in terms of how an organization fulfills its mission. Persisting with an outdated model ultimately may lead to unacceptably high financial and public-relations costs, as payers shift their business to higher-value competitors whose approaches to care are perceived as more responsible and sustainable.

How to Emulate the Leaders

The organizations that have been shifting their strategies toward value-based care generally share certain advantages: financial stability, positive relationships with physicians, advanced information systems, and (often) affiliation with a health plan. Nevertheless, several providers that lack those advantages are making progress. The investment required is as much in leadership as in dollars.

For one, the push toward building relationships with stakeholder groups internally and in the broader community is largely one of will. The innovations of the pioneers are more replicable than you may think. For instance, to maintain high quality of care and reduce rehospitalizations for patients who are discharged to skilled nursing facilities (SNFs), Intermountain now requires that the SNFs have a minimum Medicare Star Rating of 3 (out of 5) and participate in both Medicare and Medicaid. Intermountain seeks a direct dialogue with the preferred-quality SNFs about how to improve care for patients with special or complex needs, such as those who require ventilators or have behavioral health issues.

Organizations can also begin to pay more attention to the changing marketplace and, using those observations, take concrete preliminary steps to change the way they provide care. For instance, many health systems have instituted telehealth services whereby patients can have an e-visit consultation with a doctor or an advanced practice clinician, any time of day or night, via an easy-to-use Skype-like interface. Telehealth's long-term effects on spending and quality have yet to be documented, but early results are promising. Health systems would do well to explore a variety of opportunities to deliver effective care in ways that acknowledge the changing consumer landscape.

The leading providers are taking an "all in" innovative approach as they do the hard work of developing new organizational competencies and nurturing cultural change from within. Their new high-value models will give them a clear advantage over institutions that fail to act strategically now.

SPONSOR'S PERSPECTIVE

Improving Outcomes by Erasing the “Integration Deficit”

How the Application of Technology and Use of Data Will Lead to Gains in Patient Outcomes While Reducing Costs

We live in a world where our personal devices—whether they're in our pocket, car or home—can seamlessly share real-time data with each other. But the same cannot be said for a much more important area of our lives—healthcare. That's because many of the systems that record and store healthcare data across the care continuum are not integrated. Erasing this so-called integration deficit is a critical next step in healthcare's evolution as we transition to value-based healthcare.

While many stakeholders see the potential for improved collaboration, the misaligned incentives of many healthcare systems make the prospects for integration a significant challenge. Repeated tests, recurring readmissions, and an incomplete picture of a patient's overall health are often the result. By working together to manage patient care holistically, the healthcare industry can improve clinical and financial outcomes.

So if the lack of integration is the problem, how do we start working toward a solution? More connected medical technologies—implanted and otherwise—can and should play a crucial role, as will better use of data to help healthcare professionals see a broader view of their patients. Today, many of Medtronic's technologies are actively generating data, and we are working with the global healthcare community to take our technology, services, and insights and fashion them into solutions that either augment the delivery of care through better patient care management or improve overall system efficiency.

In the spirit of progress and partnership, our work includes:

- Utilizing insulin pump technology, sensors and mobile applications to better manage patients outside of the hospital setting in the Netherlands,
- Combining implanted heart failure technologies, diagnostic sensors, and nursing support to keep heart failure patients out of VA hospitals,
- Collaborating with IBM Watson to identify better care management for diabetes patients by using the patient's own data,
- Working with hospitals to allow quicker patient discharges by giving doctors and nurses the ability to monitor patient care and progress remotely,
- Partnering with hospitals to manage their cath labs for better patient throughput and outcomes, and
- Working on-site at hospitals to drive improvements in efficiency, quality, clinical outcomes, and patient experience, all within an outcomes-based payment model.

As we've seen in our efforts, the successful integration of patient care will require collaboration between providers, suppliers, physicians and payers. At Medtronic, we believe we have an important role to play in the integration of healthcare. There's an opportunity to harness the data and insights our technologies produce to create a more integrated, patient-centered healthcare system—one that ultimately is set up to achieve and reward the long-term outcomes that are central to a value-based healthcare system.

Learn more about our perspective on integrating care and value-based healthcare [here](#).

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