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# **Making the Transition from Volume to Value**

Monograph Series

## About the Author

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## The U.S. Health Care System in Transition<sup>1</sup>

The U.S. health care system is currently undergoing what will ultimately be a radical transformation, driven by unsustainable cost increases, increasing regulation, and shifting power relationships among payers, providers, physicians, and patients. Technology advances are accelerating the pace of innovation, while rising costs and demands for affordable health care and greater transparency are challenging the economics and traditional business assumptions of the field. At the same time health policy shifts brought about by the Affordable Care Act (ACA) are placing increased accountability and cost pressures on providers to improve patient safety, quality of care, and consistency of care delivered. Payers and consumers alike are increasing their demands for improved economic and clinical value (ECV).

Health care is in transition. Transition occurs when one or more of the following happens: 1) there are significant changes in the regulatory environment; 2) major technological changes come into the market; 3) new players appear, creating shifts in the competitive landscape; or 4) there are fundamental changes in market expectations. Any one of these shifts forces companies, even leading companies, to challenge fundamental assumptions about their business models, how they go to market, and the nature of products and services they offer. Each of these changes creates challenges for businesses as they adapt to new requirements and develop new capabilities, but the health

care system in the U.S. faces dynamic changes in all of these areas. To be effective in meeting new requirements—and provide “better care at lower cost”, health care leaders will need to understand the context in which changes are occurring and their impact on the entire health care field.

### *Drivers of Change*

In large part, demands for change from payers, consumers, and providers are the result of the rate at which costs of health care have increased. As Figure 1 on page 6 indicates, in the U.S., health care costs have outpaced the Consumer Price Index (CPI) for years and, despite a slowdown in the rate of growth in the past decade<sup>2</sup>, costs remain at unsustainable levels. Health care costs now constitute 18 percent of the gross domestic product (GDP)—up from 14 percent in 2000 and 5 percent in 1960—and are projected to reach 21 percent by 2023<sup>3</sup>. Similarly, health insurance premiums have increased between 3 and 13 percent per year since 2000, significantly more than inflation and the growth of workers’ earnings<sup>4</sup>.

Despite the fact that the U.S. now spends more than twice what the rest of the developed world spends on health care per person, doubts about the value consumers are receiving in exchange continue to grow. The U.S. lags behind other countries in several health indicators, including longevity, infant mortality, and quality of care realized by many other high-income countries<sup>5</sup>.

### *Health Care in Transition*

The impact of these factors on health care delivery cannot be underestimated. We have

1 Portions adapted from *Healthcare at a Turning Point: A Roadmap for Change*, Numerof, R.E. and Abrams, M.A., CRC Press, Boca Raton, FL: 2013.

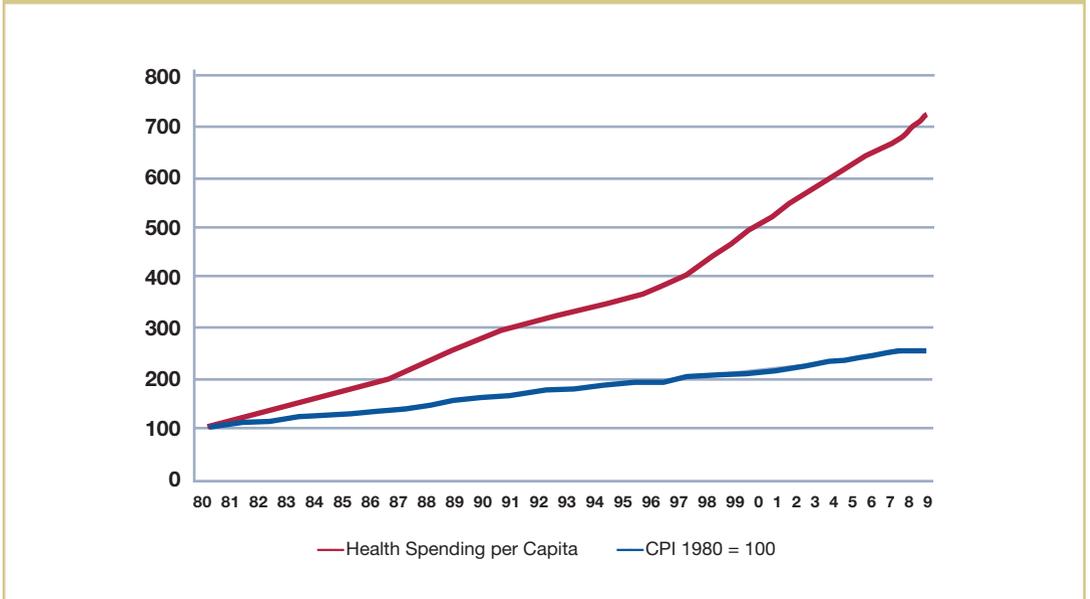
2 Since 2002, the rate of increase in national health care spending has fallen from 9.5% to 3.9%. *Health Care Costs: A Primer: Key Information on Health Care Costs and Their Impact*, The Henry J. Kaiser Family Foundation (May 2012), p. 6.

3 *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*, by The Commonwealth Fund Commission on a High Performance Health System, January 10, 2013, p. 13.

4 *Health Care Costs: A Primer: Key Information on Health Care Costs and Their Impact*, The Henry J. Kaiser Family Foundation (May 2012), p. 6.

5 *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*, by The Commonwealth Fund Commission on a High Performance Health System, January 10, 2013, p. 13.

**Figure 1 • Growth in National Health Spending per Capita and the Consumer Price Index (Urban)**



*Health Spending Data: CMS Data & Statistics; C.P.I.: President's Economic Report to the Congress, 2011, Table B-20*

reached the point where payers, providers, physicians, and patients all have significant economic concerns—providers and physicians about their revenues, and payers and patients about the affordability of care. Fee-for-service (FFS) as a payment model is now recognized as a key factor in driving up costs largely because the payments have had little, if any, connection to quality or patient outcomes. Increasingly, new payment models are attempting to connect fees to quality of care. Rising costs and demands for affordable, better quality health care are challenging the traditional business assumptions of every part of the industry, including health care systems.

As shown in Figure 2 on page 7, health care faces major shifts in the competitive landscape. Hospitals now face competitors across the country, not just across town, as major companies contract for their employees to receive treatment at “centers of excellence” such as Mayo Clinic, Cleveland Clinic, and Johns Hopkins. These hospitals compete nationally for patients based on their

quality and offer specific services (such as cardiac surgery) for a “bundled price.” At the same time hospitals face new forms of competition, such as retail primary care provided through Wal-Mart and Walgreens. In turn, many hospitals are acquiring physician practices or other hospitals as they respond to new payment schemes as well as incentives for improved quality and efficiency and care that is more coordinated across the continuum.

The regulatory environment is changing and becoming more demanding than ever for health care. To achieve comprehensive health care reform three elements need to be addressed: insurance reform, health care delivery reform, and payment reform. The ACA primarily focused on insurance reform by making coverage more accessible to more people. It did include, however, some limited incentives for certain delivery and payment reforms, including incentives for forming Accountable Care Organizations (ACOs) and bundled pricing. The ACA continues to cause ripple effects across the landscape as

**Figure 2 • Characteristics of Industries in Transition**



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significant regulatory shifts are implemented. These shifts increase pressure on providers to demonstrate accountability for cost-effectiveness, patient safety, and quality and consistency of care delivered.

Health care continues to face major technological changes, including new technologies in treatment methods, new drugs, medical devices, and novel surgical techniques, as well as changes in the administration of health care, such as the rapid adoption of electronic health records (EHRs). Some of these new technologies include remote or home monitoring of patients and a rash of new technologies focused on patient engagement and wellness.

Market expectations are changing. Payers are increasingly demanding data that demonstrate the effectiveness of treatments, while consumers seek cost and quality data upon which to base treatment decisions. For example, lacking data showing high-quality outcomes, some payers are questioning use of aggressive treatments, such as limiting or denying coverage for surgical treatment for conditions such as degenerative disc disease. As part of the movement to improve

outcomes and reduce health care costs, Medicare and Medicaid are beginning to link hospital payments to the quality of care. In addition to financially rewarding hospitals that improve care, Medicare and some other public and private insurers also are starting to refuse payment for preventable errors (i.e., “never events” such as patient falls, hospital acquired infections, operating on the wrong body part, medication errors, etc.) and imposing Centers for Medicare and Medicaid Services (CMS) readmission penalties. All those who pay for care (including consumers/patients) are increasingly focused on the demonstrated value they get.

Despite the massive changes the field is beginning to experience, many health care systems remain successful. As a result, their leaders may be reluctant to take bold steps to prepare for a new environment. Periods of fundamental transition are incredibly challenging, and require people to set aside assumptions about how many things have worked, which can make people who have established themselves based on the old model anxious and resistant. Not only does that resistance make change harder, but usually organizations need to maintain the

old model since it's still creating cash flow, even as they get ready for a new approach. It's human nature to prefer the prospect of minor change to that of major paradigm change, and there's a tendency to want to water fundamental change down into incremental change.

Health care delivery organizations now must address demands for transparency and new system requirements focused on value. Changing incentives to close the looming value gap between market expectations and what their organizations deliver is a critical job for trustees and executives who want to ensure continued financial viability.

### Lessons from Other Industries in Transition

Any business that is part of an industry in transition must address its inherent resistance to change. While the signs of a dying business model are crystal clear in hindsight, it is difficult for senior leadership to chart a new course toward an uncertain future, especially when the current model is generating significant revenue. The dangers of not recognizing the signs and planning accordingly are legend. To highlight the challenges leaders face in dealing with the complexities of industry transition, the lessons of other industries offer compelling insight. A case in point is IBM's near demise and subsequent turnaround in the 1990s.

IBM achieved market dominance as a mainframe computer company. In the mid-1980s IBM was on top of the computing world. It led the market, helping large companies install complex, mainframe-based systems. The company enjoyed ~50 percent gross margins on mainframes and held the lion's share of worldwide industry profits. It projected a bullish future with long-term projections of \$200 billion in sales. IBM held a strong reputation: "Nobody ever got fired for buying IBM." The company was, "successful beyond [its] wildest expectations," according

to John Akers, IBM CEO in 1985, despite changes occurring in computer and networking technology.

In the space of a few years, however, IBM found itself in serious trouble. In 1991 IBM began posting substantial losses; and by 1993 IBM lost \$16 billion, and company leaders were planning to dismantle and sell the company. IBM ignored the warning signs that the market was moving away from mainframes, holding on to the belief that the business computer was, and always would be, the big box. Their assumption was that personal computers (PCs) were for small businesses and home computing—at the desk in the kitchen. As IBM saw it, mainframes had great margins and proprietary technology. IBM had solid customer relationships and market-leading products. PCs, on the other hand, were a niche invention, with "upstart" companies like Dell and Compaq coming onto the scene. Even though IBM was widely credited with inventing the PC, the company didn't appreciate the serious shift in the market it would create. In the late 1980s IBM was close to filing for bankruptcy.

Despite what appeared to be the end of IBM, new leadership was able to turn the company around. IBM reinvented itself by building on its strengths and advantages centered around the services and software it provided, rather than the mainframe hardware. To deal with new market demands, IBM had to begin by improving business practices and reducing costs. Company leadership studied the market and determined that an integrated approach to providing high-margin software and services would reinvigorate the company. Although the transformation process was not complete in the 1990s, by 1995 the company was back on solid financial footing and began growing again.

A key lesson from IBM's experience is that leadership cannot ignore warning signs of major market changes—in IBM's case the key indicator of an industry in transition was rapid

technology change. PCs and networked computing were challenging mainframe-based systems.

The lessons from IBM's experience are not specific to the computer industry. The lesson for board members of any company dealing with the challenges of being part of an industry in transition is that smart and experienced leaders of highly successful companies can fail to address major change—or even upheavals—in their market and cause the failure of the company.

Health care leaders faced similar challenges in the 1980s with the end of Medicare “cost plus” reimbursement to hospitals that assured profits and technology changes that led to more outpatient procedures. These payment and technology changes had a significant impact on health care delivery and required organizations to adapt and evolve—and not all survived. The approximately 7,200 acute-care hospitals in business in 1980 fell to about 5,200 by the mid-1990s. Health care leaders face challenges of an even greater magnitude today.

To meet these challenges leadership must adequately find the answers to such basic questions as: (a) What's happening in our markets? (b) What's happening in adjacent market spaces? and (c) What are the implications of (a) and (b) for *our* business? The success of the current business model can easily blind leaders to the need to position their hospital or health care system for the needs of what's coming next—is your organization more like a mainframe (big, expensive, inflexible), or like networks of PCs (nimble, cheaper, innovative)?

## Health Care: It's a Volume Business

As we focus in on hospitals and health systems, it's critical to recognize that a fundamental problem in health care is the way services are paid for in the U.S. Simply put,

the fee-for-service payment model is not well-aligned with the goal of better health outcomes at lower cost because it rewards volume instead of value; and someone else, such as a third party payer or employer, pays. Consumers do not typically pay directly for their health care services and providers are paid based on production, so increasing costs have not been a concern. Since providers are paid for each service, not for the outcomes they help patients achieve, they do not have incentives to ensure the quality and efficiency of patient care; and are rewarded for increased productivity at the service code level. The outcomes that they achieve matter comparatively little, and research indicates that more services and higher spending do not necessarily result in better outcomes—and may sometimes produce exactly the opposite result.

Under the current fee-for-service payment model providers are, in effect, encouraged to deliver *more* care through tests, treatments, hospital admissions, etc. Not surprisingly, the result has been more spending with specialists empowered to deliver more care than may be necessary. To illustrate, the American Board of Internal Medicine, working with 25 other medical specialty societies, called into question the necessity and use of more than 130 tests and procedures. But while these societies can identify procedures or tests that are often overused or unnecessary, as long as reimbursement continues on a fee-for-service basis—without a connection to patient outcomes—the incentive to simply do *more* will continue.

Fee-for-service without any connection to outcomes creates no incentive to improve quality or increase efficiency, such as improving chronic disease management for diabetics, or reducing ER visits for low blood sugar reactions. Care delivery remains fragmented because there is no incentive to coordinate and avoid duplicating services. For example, consider the circumstances of an independent primary care doctor who is

extraordinarily proud of his ability to help his patients manage their chronic diseases—asthma, diabetes, various cardiac problems, etc. The more complicated the case, the more he gets to serve as “medical detective.” His patients appreciate him because of his thoroughness and because he can so effectively diagnose and help them manage their conditions, in contrast to their usual physician experience. As a result, they maximize their quality of life, avoiding complications, unnecessary hospital visits, and multitudes of specialists.

He takes the time to ask questions and diagnose the root cause(s) behind his patient’s symptoms, utilizing expensive diagnostic tests only when necessary. He uses visits to educate his patients, guiding them to better manage their health to avoid preventable health care interventions if their condition progresses. He coordinates care among needed specialists to whom he refers his patients and only makes referrals when he’s determined he really needs their consultation.

Unfortunately, he’s penalized in our current payment system, yet his behavior is exactly what’s needed to lower costs and improve outcomes. His time to educate patients isn’t reimbursed. Or, if he codes for an extended visit to recoup his legitimate time spent, his claim is much more likely to be flagged by an insurer as an outlier... either rejecting the claim outright or resulting in delayed payment. Unfortunately, his behavior is not typical of primary care today. It’s a much easier path for the primary care doctor to pass his patient on to a specialist, reducing his liability and increasing costs to the system.

This situation can be compared to a primary care doctor who is equally capable and also works with complicated cases—but refers his patients to specialists without spending uncompensated time asking questions to ensure necessity of care and/or treatment or providing education to patients. In addition, time is not spent coordinating care among

specialists. Patients are treated, but care is uncoordinated and, as a result, provided at greater cost.

The current situation in health care clearly points to the need for systemic change. A shift from fee-for-service to a more accountable care model means shifting responsibility for outcomes, increased sharing of risk for health care costs, and increased gain-sharing as improvements are realized. Creating different incentives and a focus on outcomes-based performance will require a coordinated effort by *all* stakeholders. Already payers are actively engaged in changing the way physicians and hospitals are paid. In the broader context of constrained resources, all those who pay for care (including consumers/patients) are increasingly focused on the “value” they receive.

The trend for payers and other stakeholders to require value for payment (e.g., pay-for-performance, bundled payment initiatives) is becoming more and more prevalent, particularly as the CMS tries to get its costs under control and private payers face increasing price resistance and public scrutiny. Beyond new payment models, indicators such as non-reimbursement for “never events” (e.g., patient falls, hospital-acquired infections, operating on the wrong body part, medication errors, etc.) and CMS readmission penalties point to an environment where payment is increasingly dependent on demonstrated value. It also marks the beginning of a shift toward more accountability.

As our discussion of fee-for-service illustrates, payment systems have implications for how well-incentivized health care providers are to coordinate care and integrate services to improve quality and manage costs. Also, it is clear that government efforts to address cost and quality will only increase. Reimbursement will continue to shift to a greater emphasis on performance and risk-bearing by providers. Government efforts to address cost and quality concerns through legislation and new

business models (e.g., Accountable Care Organizations) are continuing, including looking to risk-based payments to reduce costs. The private sector, however, still has an opportunity to take the lead in molding the business model of the future to provide better care at lower cost.

## The Business Model of the Future

There are a number of areas in health care that exhibit very different market dynamics than most areas of health care delivery. As discussed in the previous section, health care is usually paid for by a third party on a fee-for-service basis. In contrast, where patients pay directly for services, providers compete based on cost and quality. These providers demonstrate the power of a market-based, patient-centered model based on delivering value.

### *Future Model*

Lasik surgery and cosmetic dermatology demonstrate the potential of a new business model focused on value. These procedures usually are not covered by payers, which means that more traditional market dynamics consistent with other consumer industries are at work. Unlike the usual health care situation in which the patient has no line of sight to costs and little or no information about quality, patients are told what the price is for these elective procedures. They also are able to compare providers and their services to find what they consider to be the best quality at the lowest price. One impact is that competition and technology lead to demonstrable improvements in both cost and quality. Corrective eye surgery (radial keratotomy) cost approximately \$8,000 15 years ago. Lasik surgery, using newer laser technology, has improved patient outcomes, reduced recovery time, and now costs approximately \$2,000 per eye.

Lasik surgery and cosmetic dermatology providers must compete for patients'

business and, as a result, these providers typically offer greater convenience, lower prices and innovative services unavailable in traditional clinical settings. In addition, these providers are transparent about their fees—patients can compare prices before treatment; and the price usually covers an entire set of services, unlike prices for other health care services. These providers demonstrate how a transparent payment model tied to outcomes that patients value creates incentives for providers to deliver better care at lower cost.

### *Who (Else) is Making the Transition?*

Even in more traditional health care provider settings, hospitals are beginning to compete in new ways. An increasing number of hospitals are redefining competition outside of third party payer arrangements for a range of services. These hospitals are, in effect, selling their quality and cost-effectiveness in a number of treatment areas to employers on a nation-wide basis. For example, Lowe's and Boeing have entered into agreements with Cleveland Clinic for fully covered cardiac surgery. Lowe's recently expanded their plan to include chronic pain management and spinal surgery. PepsiCo has a similar arrangement with Johns Hopkins Hospital that covers employees' cardiac or complex joint surgeries. Recently, Wal-Mart Stores announced that employees covered under the company's health insurance will now be able to receive at no cost heart and spine surgeries at one of six health systems identified as "centers of excellence" for each service.

Cleveland Clinic has similar programs for employees of Kohl's, Rich Products, and Alliance Oil. Other companies have, and are developing, similar arrangements with other hospitals. This trend is not limited to a small number of high-profile hospitals. Other health systems are also working to establish similar relationships with companies and payers. Grocery store chain Kroger Co. has agreements with 19 hospitals for specific

services, and medical benefits companies have brokered similar arrangements between employers and at least several dozen hospitals across the country.

These developments have important implications for hospital board members who are responsible for ensuring the continued viability of their health care systems. Looking to the future and ensuring the identification of risks and opportunities is part of that fiduciary responsibility. Demands for value already are having significant impacts and changing market dynamics. Providers that can demonstrate their value in terms of high-quality care and patient outcomes are now competing for patients on a national basis. The nature of competition is being redefined at an accelerating rate. Many health care systems increasingly find themselves unable to compete with new market rules.

Not only are these providers competing nationally in new markets, they're using new payment models to do so—namely, bundled rates or fixed payment amounts. Hospitals can ensure a stream of business from these arrangements based on their demonstrated quality. Employers see a number of benefits, including a fixed price, overall cost savings, and better care for employees. Patients benefit by receiving care from providers with a demonstrated quality of care and fewer complications. These providers save both employers and patients from the costs of additional procedures or complications.

### **How Should Hospitals and Health Systems Change?**

Many health care systems remain successful despite the massive changes the field is beginning to experience. As a result, leaders are often reluctant to take bold steps to prepare for a new environment. But as the previous sections should demonstrate, the “wait and see” tactic is extraordinarily risky in this case. Health care delivery organizations that wait or are slow to meet demands for

“better care at lower cost” by shifting from a volume to value model will be left behind. The transition is neither quick nor painless, and those who wait too long to “start their engines” may run out of runway. At some point payers will drop or skip over providers that cannot demonstrate value and quality. Changing incentives to close the looming value gap between market expectations and what their organizations deliver is a critical job for health care leaders who want to ensure continued financial viability.

Going forward, health care leadership must ensure their organizations have a market-based, patient-centered approach—that provides demonstrated value to stakeholders. In every other industry, advancing technology has generally resulted in lower costs and improved products and services. It has not worked that way in health care. Without a true market-based approach to health care delivery, it will not be possible to address cost and quality issues in a meaningful way. And, as the previous section illustrates, there are health care systems today that can demonstrate their value to key stakeholders, most notably large employers, and compete for patients in new ways on a national basis. Transparency, increased accountability, and a consumer centered model for health care are quickly becoming the basis for achieving the goal of better health outcomes at lower cost.

To compete in a market-based, patient-centered approach, providers must invest in the models and infrastructure necessary to demonstrate better care. Providers need to be able to offer care that is differentiated, delivering more value as defined by the health care consumer. As the previous section demonstrates, a starting point is bundled payments. Cleveland Clinic, Mayo Clinic, and other health systems are providing value to stakeholders by using a bundled price, which is not necessarily the least expensive, for services in certain areas. These providers can define and deliver on better health outcome metrics.

Creating a bundled price is an exceptionally difficult undertaking. Organizations must develop the right financial and clinical infrastructure (i.e., predictive care paths, evidence-based medicine) to deliver a standard set of services. Providers must ensure that treatment protocols reflecting a specific course of treatment would be followed in a consistent fashion. Reducing practice variability and understanding the causes of it are essential to any attempt at bundled payment. Identifying the key drivers of treatment cost and variability requires an ability to manage data, people, and resources; tools for understanding variability; and mechanisms for managing variability that are necessary to implement fiscally safe new pricing. Providers will also need to define the key economic and clinical components of value they provide to patients, payers and employers, which involves developing the data needed to demonstrate better health outcomes and commensurate value for their price, as shown in Figure 3.

To be successful, both administrative and clinical leaders must improve their ability to reduce unnecessary variation in medical practice, both to improve care and manage costs more effectively. “Value” will require identifying and eliminating wasteful and

unnecessary care and improving operational practices to reduce medical errors and complications to ensure both quality of care and cost-effectiveness. Physician leaders must ensure that clinicians understand the linkage between quality, payment, and compliance (e.g., determining whether the care provided is ‘necessary and appropriate’). Understanding must translate to behavior, and compliant behavior will be critical in dealing with increased scrutiny by regulators and in succeeding with new payment models such as bundled payments.

Improved care coordination and alignment is another critical component of health care delivery focused on value. This means payment systems must change the incentives that have led providers (hospital, physician, laboratory, etc.) to duplicate tests and services. Senior management will clearly need to invest—such as hiring more individuals with the explicit responsibility of care coordination (e.g. care navigators), and paying for additional services (e.g., phone consultations)—to achieve better overall outcomes and prevent additional costs down the road. Clearly, care navigators are a commercial response to a fundamental problem. While navigators can be helpful in managing the symptoms of uncoordinated delivery, *they don’t fix the underlying problem.*

**Figure 3 • Competing on Value with Bundled Payments**



*A defined set of services with a specified quality outcome delivered at a predictable, transparent price, across the continuum of care. Copyright © Numerof & Associates, Inc., 2010-2013.*

All of these changes mean board members must know how effective their organizations are at removing inefficiencies, reducing costs and improving outcomes. Going forward, unreliable or unnecessary care and medical errors are just too expensive to be tolerated<sup>6</sup>. That means leaders must ensure that their hospital's systems are effective in the collection and reporting of quality data. For clinical leadership, that means ensuring documentation, including charting and clinical documentation, is *consistently* accurate and complete.

In the context of bundled pricing and associated cultural challenges, trustees must ensure that the organization produces sufficient information to enable leadership to make the best decisions possible; develop policies that promote the involvement of administrators in the review of clinical decision making; ensure that care path adoption is evaluated and monitored; and ensure that managers and physician leaders are held accountable for engaging in difficult conversations with physicians.

Promising to deliver a standardized set of services for a fixed price with specific quality guarantees will finally force care providers to align their efforts to contain underlying cost drivers. Taking action on such issues as overutilization, technology choices, and inadequate coordination across the care continuum can drive meaningful change in cost and quality—but only if providers are uniformly focused on these outcomes, without the distortions caused by the current fee-for-service approach that pays without consideration of outcomes.

Concurrent focus on developing a case for differentiated clinical value that can be offered in the market will ensure a balanced approach that doesn't forgo quality and safety for the

sake of economic efficiency. Such efforts require major paradigm shifts in thinking at the top, and new competencies and focus within the management infrastructure. Developing that infrastructure will require organizations to challenge historic norms and fundamental business assumptions, ultimately leading to the creation of a new business model.

## What Can Boards do to Drive Change?

As the preceding sections illustrate, the push for transparency and quality improvements (part of the shift from volume to value) in health care will continue to create demands on governing boards to improve their oversight capabilities. The traditional board focus on finances must expand to include quality issues, especially as fiduciary responsibility of board members has expanded to include quality of care. Boards play a critical role in defining health care organizations through their oversight of a range of issues including finances, infrastructure, medical staff, and compliance. Boards must now lead efforts to determine what "value" means for their organizations.

In the current environment, boards are challenged to examine and determine the course of action for dealing with new payment and business models. Yet, many health care systems remain successful and leaders may be reluctant to take bold steps. Uncertainty and hesitancy in addressing demands for change can show up in a number of ways. Governing boards of any business are obligated to recognize the magnitude of change facing their organizations and determine what is required to meet future demands. Boards should listen carefully to what senior administrators are telling them, being sensitive to signs of resistance.

6 CMS has instituted tough penalties for inappropriate care—1 percent of the institution's total annual Medicare reimbursement.

Boards frequently hear...	which usually means...
We're in discussions with ABC System and XYZ. They're not competitive but they're in similar markets so we're able to learn from them.	watchful waiting
We have four dedicated committees looking at this; they meet regularly and are studying what others are doing.	confusing activity with results
We don't want to move too early and jeopardize our FFS business. We'll move when we need to move.	implementation denial
We're really market leaders and people want to join us. This, too, may pass.	market denial
We don't want to get ahead of CMS. There's still lots of uncertainty.	watchful waiting
Payers can't process claims differently and with our increased market power, we'll be in a better negotiating position.	market denial

Does leadership recognize the magnitude of change their organization and the industry are facing? (a) Does leadership really understand what's happening in our markets? (b) What's happening in adjacent market spaces? and (c) What are the implications of (a) and (b) for our business?

### Board Accountabilities

The transition from volume to value is exceptionally difficult, beginning with the trend to measure hospitals on their quality, safety, and cost-of-care as part of transparency and payment initiatives. In determining how to address these issues in their organizations, boards of directors may find it helpful to review accountabilities critical to creating sustainable change:

- overall organizational performance (and culture);
- understanding and challenging assumptions about the quality and cost of care;
- guiding the future of the organization, ensuring commitment to mission and sustainability;

- leveraging the talents and skills of board members (and improving board member skill sets);
- developing effective ways to focus on the right issues such as, ensuring ongoing board education and receiving input from staff and patients.

As a practical matter, these accountabilities outline the range of issues boards must address as they focus their efforts on transitioning from volume to value. Boards must acknowledge their role in creating value and ensuring quality and safety. Boards must have an active quality committee with full board engagement—quality and safety need to be considered key strategies for health care organizations, with board support and resources to support these efforts. Boards must set performance goals, specifically safety and quality goals for the organization, with meaningful targets that can be achieved in a defined period of time. Quality committees (and boards) should be able to effectively use data from different sources. Data should be reviewed regularly to understand progress and issues the organization faces. Boards

also should review input from patients and from staff on quality and safety issues and events—to help focus on these issues and create a proactive and positive emphasis on improving the organization.

Boards need to reinforce their organization's commitment to quality and safety through various efforts, including recognition, engagement, and ensuring that leadership hiring requirements include criteria and accountabilities for quality and safety initiatives. Boards also need to engage physician leadership on safety/quality issues, establish accountabilities (e.g., by service line) and support physicians' leadership with resources and collaboration. For board members, one place to start is by examining

their own skill set, as shown below.

### *Questions for Board Members*

In the previous sections, we discussed how providers that can demonstrate their value in terms of high-quality care and patient outcomes are now competing for patients on a national basis. Many of these providers are using bundled payments to provide employers with certainty about cost and the clear value proposition their organization demonstrates (better care, quality outcomes without complications, etc.). Even if a hospital does not want to develop a bundled payment for any of its services, it should consider examining the capabilities required to do so. Understanding cost of care delivery and being able to effectively manage variation in cost and quality will only benefit hospitals,

## **A Short Example of Board Self-Assessment Considerations**

### **Questions for boards to consider:**

- Mission—Quality of care is a key part of a hospital's mission. What are your organization's quality (and safety) goals? Are these values communicated in a manner that reflects the organization's culture?
- How much of the board's time is spent on quality issues (at least 25%)? Is the board comfortable with transparency requirements?
- Does the board receive formal quality performance measurement reports?
- How effective is your board overall and its Quality Committee in the following respects:
  - ✓ Does the committee understand clinical quality data? Is there understanding that quality is also a compliance concern and quality of care is increasingly integral to payment?
  - ✓ Does the board interact with administrators to promote and incentivize quality?
  - ✓ Does the board interact with physician/nursing leadership and medical staff to promote quality/safety and engage them as partners on quality issues? Does the board ensure accurate collection and reporting of clinical documentation and quality data? Do clinicians understand the relationship of quality to payment, including accurate documentation to justify payment?
  - ✓ Does the board ensure system capabilities are sufficient in these areas to meet transparency requirements (i.e. enhanced reporting and disclosure requirements)?
  - ✓ Does the board receive input from patients on their experiences and ideas (positive and negative)?
  - ✓ Are discussions about quality issues at the board level sufficiently robust or superficial?
  - ✓ Does the board chair facilitate in-depth discussions of performance quality metrics? Are quality issues addressed by setting goals?
  - ✓ Do board members take their responsibility seriously by probing into issues?

both in financial and quality terms.

For boards that are preparing for or working on bundled payment initiatives, there are a number of questions board members might ask to guide efforts related to the development of a bundled price for a specific treatment or set of services.

### *Sample Questions About Bundled Pricing*

- What organizational capabilities do we have in place to develop a bundled price?
- Where are we in the process of developing a bundled price?
- How well do we understand where variation in cost and quality exists for the top five service lines?
- How well do we link variation to outcomes?
- How are we reducing variation and optimizing outcomes?
- How do we hold providers accountable for “best practices” reflecting evidence-based medicine?
- Is the price linked to relevant quality metrics and how?
- How do we compare to others?

Clinicians who drive spending through treatment decisions (e.g., tests, treatments, hospital admissions, length of stay) will play a critical role in controlling costs—and will be challenged to improve quality at the same time. There are a number of questions board members might ask to understand and guide efforts related to a specific improvement in clinical management.

### *Sample Questions About Clinical Improvement*

- Do we understand where variation in practices and processes exists? What do we do to manage variation?
- Do we understand relevant quality and safety issues and risks?
- What are the goals of the quality improvement effort? What are the metrics? Are the reported data meaningful?
- How is this effort linked to management accountability?
- How is the quality improvement effort reflected in organizational policy?
- Does the board need to add members with relevant clinical expertise?

The landscape for health care is changing rapidly. Demonstrating “value” means health care providers must meet demands for transparency in quality and cost. New payment models create operational and cultural challenges for health care organizations. The shift from volume to value will require governing boards, administrators, and clinicians to change their perspective on health care delivery and look at their operations, financials, quality metrics, engagement and outcomes differently. Health care leadership will need to look at care delivery from a broader perspective than in the past, focusing on costs and patient outcomes across the care continuum. Those that engage in the journey today in a disciplined way will be the leaders tomorrow. It isn’t a matter of “if we should,” it’s a matter of “when and how we start.”

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