The Volume vs. Value Scale: What Is the Tipping Point in Your Market?

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A prerequisite to participate at the board level of a hospital or health system in the United States is the ability to be comfortable with what appear to be major contradictions. Seemingly simple questions can appear to have wildly different and contradictory answers.

Key Board Takeaways

Value-based care is clearly the way of the future, but making decisions related to the transition away from volume is no easy task for the board. Two important pieces for the board to understand are that successfully knowing how and when to migrate from volume to value is:

- Largely dependent on local market dynamics, not national trends
- Necessitates thinking about your value-based business as an entirely new business, not an extension of your existing operations

For example, when asked the question "How much of our revenue in three years is expected to be *value*-based and how much will be fee-for-service?" a perfectly acceptable response is "We expect our revenue to be 60 percent value-based in 2019 and 90 percent fee-for-service." Another example is looking at the upcoming board meeting agenda where the topics of how to increase service line volume and how to reduce hospitalizations via population health management will be discussed back-to-back. Psychologists tell us that when presented with such contradictions, humans are highly motivated to reduce the discomfort by selectively ignoring information and/or actively avoiding situations where such topics are discussed—neither of which makes for good governance.

The Current Challenge

How is it that the future of value-based care can seem so clear at the national level—with CMS ahead of its stated goal to migrate 90 percent of Medicare payments to value and 50 percent to so-called alternative payment models (i.e., risk-based models) by 2018—while at the same time being so murky within your market? This contradiction is at the heart of why it is so challenging today to sit on a management team or board of a hospital or health system in the United States. To resolve this apparent contradiction, it is important to start at the root of the problem.

Acute healthcare in the United States is the best in the world. However, only a small portion of people need those services in any given year. Yet, we have designed our delivery system around sophisticated treatments and our payment system has evolved to reward high volumes of those treatments. To bend the cost curve, those who pay the claims have steadily ratcheted down the price per unit. Predictably, providers responded by increasing productivity and efficiency.

A consequence of the above is that though there are fruitful avenues left to pursue to improve both productivity and efficiency, we are nearing the limits of what they can achieve and neither is sufficient to solve the affordability problem. Adding insult to injury, we have materially underinvested in prevention and management of disease resulting in significant variability in cost and quality of care. The prototypical illustration of the current state is the person who has congestive heart failure. This condition is marked by the heart pumping blood inefficiently resulting in fluid backing up in the lungs and the patient feeling short of breath. Changes in diet, minor infections, and deviations from their complex medical regimens can exacerbate their symptoms and tip the balance away from stability toward a health crisis. Fortunately, the process is correctable when caught early. In the early stages of the shift, these patients experience shortness of breath. When this happens most patients call their doctor for an appointment. Unfortunately, it is all too common that their doctor's schedule is full (since they are maximizing productivity) and they cannot be seen for several days when it is too late.

So what happens? Once the patient is in enough distress, we can send an ambulance right away to take the patient to be immediately seen in the emergency department and even given a place to stay for a couple of nights until they are again stabilized. Sometimes we send them to a skilled nursing facility until they are back on their feet. Though the acute care received by the patient is top-notch, all of this could have been avoided at multiple points along the continuum ranging from better nutritional

counseling, improved medication management, better monitoring at home, and of course, improved access to the doctor's office.

While it is clear what we should do, the way we pay for healthcare does not support those actions and in fact actually works against us. Over the years, we have become masters at being able to deliver and bill for services and somewhat oblivious as to what is going to get the most bang for the buck. Although we can shift incentives to align the patient's needs with the provider's economics, we do not operate in a single-payer system so changing contracts is not like flipping a switch. Also, when you move the money without changing the care model or infrastructure most systems have failed to get the results they sought. In addition, shifting from one care model to another turns out to be much more difficult than people anticipated.

Transitioning to Value-Based Care

Fortunately, we know what does and does not work. We also now understand the steps required to operationalize a value-based delivery model while still successfully operating a fee-for-service business. All healthcare is local and all successful value-based delivery transformations account for those local market dynamics. Do you have a dominant commercial payer or several payers? Do you have excess specialty capacity or shortages? Are your ORs and beds full? What about ambulatory surgery center (ASC) capacity? Is your cost of care (total and by episode) high or low relative to regional benchmarks? What about your unit pricing and actual costs relative to competitors?

A big part of being successful during this transition is to approach your value-based activities as a separate business. Trying to change the entire system incrementally all at once is a recipe for mediocrity. Better to focus efforts on a specific area or two and fully transition the clinical and economic model. This will allow you to properly align incentives, set up the right metrics, and truly understand just how well you are solving the affordability problem in your market.

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