Harvard Business Review

**REPRINT H02CDE**
PUBLISHED ON HBR.ORG
SEPTEMBER 17, 2015

**ARTICLE**
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Implementing a value-based strategy is on the mind of nearly every health care organization in the U.S. It seems that every week, one or another announces a new "Center for Health Care Value" or "Center for Health Care Innovation." These organizations are accepting the fact that the volume-driven system is in its dying days, and that the future will demand that they deliver demonstrably better value: improved outcomes, lower costs, or both.

Many institutions are overwhelmed by the change required and don't know where to begin. As Michael Porter and Thomas H. Lee recently described in the HBR article "The Strategy That Will Fix Health Care," implementing a value strategy involves dismantling specialty departments in favor of condition-specific practices, being paid and held accountable for results, pursuing geographic expansion, and more. It is a formidable transformation. But some institutions are succeeding, and we find that nearly every element of their value strategies builds on and is strengthened by one thing: the ability to measure outcomes.

Here are five reasons why:

**1. Outcomes define the goal of the organization and set direction for its differentiation.**

Few health care organizations have made it their explicit goal to deliver excellent outcomes. Providers commonly cite quality, research, or education as goals, but few measure their patients' treatment outcomes or report them – either to their clinicians or the public. Improving value can only happen when providers align the focus of their clinical teams and their market strategy on achieving excellent outcomes, and in turn invest the resources to measure and report them.

In 2005, when Prof. Dr. Hartwig Huland led the opening of a Martini Klinik, a new prostate cancer center in Hamburg, Germany, he wanted to deliver the best care in the world for its patients, and he defined "best" in terms of outcomes: rates of cancer recurrence, incontinence, erectile dysfunction – things everyone knew were important but few measured. Focusing first on clinical excellence and driving his team to measure and improve it, Huland's center gained a regional, then national, then international reputation and is now the highest volume center for prostate cancer care in the world. (See this Harvard Business School case for more.)

**2. Outcomes inform the composition of integrated care teams.**

Clinical training is inherently siloed, but value-based health care requires integration around the patient. This is not easy for specialists who are not used to working closely together, or worse, even dislike each other. But defining and measuring outcomes can bridge the disciplinary divide as teams must necessarily collaborate to achieve better results. Data that exposes poor performance in particular can be a strong motivator to join together to improve.

At Texas Children's Hospital (TCH), in the early days of its pediatric cardiac surgery program, newly recruited director Charles Fraser investigated the hospital's performance relative to national referral centers as reported in the literature. The conclusion was disheartening – on most procedure types, TCH significantly underperformed. Citing its outcomes performance as a mandate for change, Fraser set about a complete restructuring of the team: pediatric cardiac surgeons and cardiologists started collaborating more closely, dedicated pediatric cardiac surgery operating rooms and ICU space was created, and a systematic outcomes tracking program was put in place. The final result? Today, TCH

enjoys a nationally recognized program with mortality rates significantly below the national average. (For more, see this HBS case.)

**3. Outcomes motivate clinicians to compare their performance and learn from each other.**

Comparison of outcomes is essential to disseminate innovations from one individual or team to another. Unfortunately, most quality measurement has focused narrowly on complying with evidenced-based processes. Although such compliance is important, it has limited impact on outcomes (often less than a quarter of variation in outcomes is estimated to be due to compliance with these processes). A more comprehensive focus on processes *and* outcomes and their interaction always shows opportunities to improve, from increasing survival rates and long-term functioning to reducing complications and speeding recovery. Comparing these types of outcomes in a transparent and collaborative way can be a powerful motivator for improvement.

This philosophy underlies a remarkable collaboration between Blue Cross Blue Shield of Michigan (BCBS Michigan), the state's largest commercial payor, and a collection of public and private providers in the state. These "Collaborative Quality Initiatives (CQIs)," financially supported by BCBS of Michigan, focus on state-wide outcome measurement for particular medical conditions or procedures coupled with frequent in-person discussions among would-be competitors to understand variations in practice and performance and to debate how best to improve outcomes. This data-driven dialogue across the network dramatically speeds the identification and adoption of best practices. For example, in 2008 the network discovered high rates of complications in bariatric surgery patients who had deep venous thrombosis (DVT) filters placed during their operation. Within one year of the network-wide meeting where the results were discussed, DVT filter use dropped by 90%. Nationally, the FDA communication warning against use of such filters lagged by more than two years, and is still being implemented.

**4. Outcomes highlight value-enhancing cost reduction.**

Alongside influencing outcomes, clinical decisions also drive the cost of care: choosing which drugs to prescribe, which procedures to perform, and whether to admit patients to acute care facilities have significant cost impact. The trouble is, clinicians generally overestimate the benefit of their care, which means that many decisions lead to high costs with little impact on outcomes. Getting costs under control requires engaging clinicians with data that can help them understand which activities and services can be reduced or eliminated without compromising outcomes.

At the Massachusetts General Hospital (MGH), amidst an aggressive shift from volume-based fee-for-service contracts to risk-based population contracts (which put providers at risk for the cost of care), the Division of Population Health Management team knew it needed a better process for determining who was best served by resource-intensive procedures, particularly those such as gastric bypass, diagnostic coronary catheterization, and lumbar fusion whose efficacy was uncertain. Rather than require that physicians follow rigid protocols, the Division created a decision support system to help

clinicians determine when a procedure was indicated, based on a patient's clinical circumstances. Criteria from the literature regarding the appropriateness of various procedures were integrated into the electronic medical record, and patients received videos and handouts explaining the risk and benefits of the various treatment options, as well as personalized consent forms that adapted those risk and benefits for their specific circumstances. The entire system was informed and refined by ongoing tracking of outcomes, as reported by both patient and clinicians.

Clinical decision making improved; for example, rates at which patients were determined to be "maybe" or "likely" appropriate for diagnostic catheterization climbed from 86% to close to 97%. Patients' confidence in their own decision making also improved. One of the local private payors was so happy with the impact that it agreed to waive the requirement for prior authorizations on all procedures for which this system was in place — a triple win for patient, provider, and payor.

**5. Outcomes enable payment to shift from volume to results.**

As payment transitions from a fee-for-service world to a value-based world, good outcomes are shifting from a lofty idea into a business imperative. Paying for results and packaging payment into a bundled price will create a fundamentally different marketplace dynamic. At present, it is unclear which provider organizations will win business and which will lose business in this environment. It is clear, however, that without a clear knowledge of their outcomes, no provider will be able to succeed with bundled payment contracts.

In Stockholm County, Sweden, the single payor wanted to expand the delivery of hip and knee replacements to eliminate long waiting lists. Armed with two decades of detailed outcome and case-mix data from the national registry, the payor developed a reimbursement model that packaged pre-operative, operative, and early post-operative care into a single price with a two-year warranty (five years if an infection was found in the first two years). Although the pricing of the model was 20% lower than the typical market price, several small, focused private providers signed on. With a clear price but greater flexibility on the delivery of care, these providers set about streamlining operational efficiencies and adding in outcome-improving steps. Within two years, the volume of hip and knee replacements delivered at these small specialty hospitals tripled while full-service hospitals watched their volumes drop by 20% (see this HBS case for further reading). Now the initiative is being expanded across the country and in seven other conditions.

Earlier this year, the Centers for Medicare and Medicaid announced that by 2016, 85% of payments will be linked to quality. Private payors are joining arms with CMS in pushing this agenda. In other advanced economies, similar initiatives are underway. The value-based shift is upon us. If you are leading a health care provider organization and are uncertain how to navigate the shift, we have one suggestion: start by measuring your outcomes.

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