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Perspective

Putting the Value Framework to Work

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"Value" is a word that has long aroused skepticism among physicians, who suspect it of being code for "cost reduction." Nevertheless, an increasing number of health care delivery organizations, including my own, now describe enhancement of value for patients as a fundamental goal and are using concepts developed by Michael Porter (see 10.1056/NEJMp1011024, and the framework papers in Supplementary Appendixes 1 and 2 of that article) to shape their strategies. What has changed? And what are these organizations actually doing?

Practical motivations lie behind the interest in the value framework. Rising costs and a stagnant economy pose problems with no easy solution. Budgets cannot be planned responsibly by hoping for growth in volume. As all players try to protect their incomes, nerves are fraying. Physicians are pitted against hospitals, specialists against primary care physicians, academics against the community.

In this fractious context, value is emerging as a concept — perhaps the only concept — that all stakeholders in health care embrace. Providers, patients, payers, and policymakers all support the goal of improving outcomes and doing so as efficiently as possible. No one can oppose this goal and expect long-term success, just as no one in a for-profit company can resist decisions likely to enhance long-term shareholder value. The value framework thus offers a unifying orientation for provider organizations that might otherwise be paralyzed by constituents' fighting for bigger pieces of a shrinking pie.

So how is the concept of value being translated into reality? As is often true in medicine itself, the critical first step is measurement. Provider organizations need to capture data on the outcomes that matter to patients, as well as the costs for a patient over meaningful episodes of care. These data are essential for assessing whether value is improving.

This work is not easy, because the collection of such data has not been encouraged by the fee-for-service system and is hindered by the silos in the current organizational structure of medicine. Current information systems are designed to support clinicians in performing individual services for individual patients and to collect their reimbursement. Outcomes as important as death are not routinely recorded; functional-status outcomes (e.g., whether a patient with head-and-neck cancer can swallow or talk) are buried in free text and are not captured in analyzable

form. The physicians with whom I practice get sophisticated, unblinded productivity reports each month on how many visits and relative value units we have each "produced." But we have never received reports on how many of our patients had emergency department visits or readmissions to the hospital.

At least not yet. Those reports are coming — some of my colleagues are already getting them. When they arrive, I expect that we will point out the inadequacy of risk adjustment, which makes comparison of rates among physicians meaningless. But we will look very carefully at the lists of names of patients and wonder how the visits and readmissions could have been avoided.

When measurement is oriented toward what happened to patients instead of what services were performed, interesting challenges and opportunities arise. For example, we are realizing that we need to expand our ability to measure and manage "cycle times" — the intervals between key moments in patients' care. Some of these intervals have obvious implications for patients' medical outcomes, such as door-to-balloon time for patients with myocardial infarction.[1]

Calculating important intervals gets difficult when care is delivered in different parts of the health care system, but the clinical implications can be enormous. If patients who present to the emergency department with a transient ischemic attack are seen promptly by clinicians in stroke clinics, the 90-day risk of stroke falls markedly (from 9.2% to 3.2% in one study[2]). If patients who have been hospitalized for a high-risk condition are seen within a week after discharge, their readmission rates are substantially reduced.

Measurement of such intervals and the outcomes that they influence is in its infancy in my organization, as in most others. And as the saying goes, if you can't measure it, you can't manage it. We are finding that just the collection of such data requires organizational change and the weakening of walls between our silos.

Which brings me to the "bad news" that goes with orientation toward improvement of value. Making progress in the value framework requires real teamwork, which sometimes seems an unnatural act in health care. It means capturing data in different parts of the delivery system, which means that we all have to use the exact same terminology. And it means sharing accountability for performance. Who should be held responsible if a patient with heart failure is not seen within 7 days after discharge? The hospital? The primary care physician? The specialist?

The answer, of course, is "all of the above." Improvement in outcomes or reduction in costs of care cannot be achieved without active cooperation among providers, which is difficult to achieve if they're all functioning as separate business units. The value framework thus makes enormous demands for cultural and organizational change among health care providers. It pushes them toward functioning as one organization focused on delivering excellent outcomes as efficiently as possible.

Which brings us to the good news: difficult though they may be, these changes feel like the right thing to do. To improve outcomes and efficiency for patients with specific conditions, providers must organize interdisciplinary teams around those conditions. In my organization, teams focused on stroke, colon cancer, diabetes, and other diagnoses are currently developing "value dashboards." They are identifying "pause points" in patient care and defining what steps should happen routinely at those points. An example might be ensuring that palliative care consultations are offered to patients with newly diagnosed lung cancer, a strategy that was recently shown to improve both the quality of life and survival.[3] Each item on these "checklists"[4] is being chosen because of the expectation that reliable performance should lead to better outcomes, greater efficiency, or both — in other words, improvement in value.

My colleagues appreciate that the value framework is not primarily a tool for competition or comparison among providers. Porter's outcome hierarchy makes clear that there are multiple outcomes that matter for any patient condition (see "Measuring Health Outcomes" in Supplementary Appendix 2 of the article by Porter), and they all have different units of measurement. There is no useful way to weight them, add them, and divide them by a dollar figure to derive value ratios to be compared among providers. But you can detect change — one hopes in the right direction.

The goal of the value framework is to create a context for improvement, for every physician and provider group to try to be better this year than it was last year. Value can be enhanced by improving one or more outcomes without compromising others or

by reducing the costs required to achieve the same levels of outcomes. The competition is with oneself. That feels like a fair fight — and worthwhile work.

In the effort to improve the value of their own care, providers look at data on the outcomes and costs associated with other providers through a different lens. These data offer the opportunity to learn. If a certain provider group has a much lower readmission rate than others, the value framework should drive the other providers to ask what that group is doing right, not worry about the adequacy of the risk adjustment.

No one should expect the value framework to be easy to implement. The measurement of outcomes and costs, the organization of clinicians into teams focused on improving care for patient populations, the evolution of a payment system that rewards providers who are more effective in improving the value of their care — these are all formidable tasks. That work is under way in my own organization and many others, but it will require many years. Indeed, it will never end.

Furthermore, a focus by providers on improving the value of care is unlikely to be sufficient to address completely the economic challenges facing health care. Almost surely, patients will be forced to bear more costs, benefits will be limited, and increases in providers' rates will be restrained in a variety of ways. But the need for such cruder strategies and the damaging effects of their unintended consequences can be reduced if providers orient themselves toward higher-value care.

Nothing can be considered guaranteed about the future for physicians and other health care providers except that there will always be patients who need care. In these uncertain times, health care providers need a path forward. The value framework provides one.

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