ISSUE BRIEF

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Navigating Quality Forward

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Investing in Healthcare Value

EXECUTIVE SUMMARY

The U.S. healthcare system needs to change its orientation from one that emphasizes volume to one that emphasizes value. In other words, it does not need to do more—it needs to do better in delivering superior patient outcomes at an affordable cost. Improving value requires significant investments in infrastructure, and these investments require capital. Wall Street has been leery about investing in value, because of the many contradictory voices on quality, the absence of pertinent performance measures, and the lack of a clear causal link between quality and financial returns. But this reluctance is beginning to wane. Evidence is accumulating that suggests that an investment in quality leads to good financial returns. Promising developments are under way in public reporting, payment policy, and delivery system design, and investor interest in banking on quality is growing. Strong multistakeholder leadership and action will be needed to achieve the vision of moving from volume to value. Purchasers and health insurers will need to develop payment policies that reward value; consumers will need to direct their "market share" to healthcare organizations that deliver on value; providers will need to build high-performing health systems that are capable of delivering value; and investors will need to provide capital for the development of a healthcare infrastructure that advances value.

This Issue Brief draws upon the presentations and discussion at the NQF Leadership Colloquium on Investing in Healthcare Value held in Washington, DC, in May 2008, which included business and Wall Street leaders; healthcare systems leaders; experts in HIT and performance measurement; consumers; and others. Subsequent to the meeting, a global recession ensued, including the collapse of credit markets as well as some institutions that make capital available for healthcare. It is unclear at this time how the crisis will affect progress toward investing in value.

Changing the View: From Volume to Value

The U.S. healthcare system perpetuates an unsustainable paradox. At the same time that more and more healthcare services are provided, accompanied by ever-increasing expenditures, the actual improvements in overall healthcare quality continue to be meager.[1] The returns on these public and private investments in our healthcare system may be diminishing, even though the United States has the highest per capita expenditure for healthcare in the world. It has been apparent for nearly a decade now that fundamental system-wide transformation is needed in healthcare,[2] but moving toward this transformation may seem to many to represent an insurmountable challenge.[3]

Large investments in infrastructure supports and capabilities are needed to achieve higher levels of healthcare quality in areas such as health information technology (HIT); the design of care processes that continuously measure and improve; and the ability to assemble and deploy multidisciplinary teams to coordinate care across patient conditions, services, and settings. Such investments require a great deal of capital that currently comes from two primary sources: revenues from operations and funds

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"To improve systemness, we must have radical payment reform. We should start using the term *radical*."

–Helen Darling, President, Washington Business Group on Health

from investors. Both of these sources currently are being used to support the status quo, but it is clear that they need to be redirected in order to support transformative changes.

Today's healthcare payment structures encourage a focus on the volume of healthcare services that are delivered rather than on the value of the services that are provided. Indeed, "we pay for things in a way that promotes doing more, not doing better."[4] The current fee-for-service payment structure has given rise to a variety of problems, including overuse and underuse of services. Overuse is particularly prevalent for services for which payments are high relative to the resources that are required. Conversely, underused services are usually those that are not included in fee schedules, such as care coordination, or those for which payment is low relative to the resources required to produce them, such as primary care. The incentives in the healthcare system reinforce the status quo by rewarding volume over value, lead to the measurement of individual services rather than the measurement of overall outcomes, and emphasize the efficient production of services, but not necessarily responsiveness to patient preferences.

Approximately $2.1 trillion are moving through the U.S. healthcare system[5]—there is no scarcity of private capital invested in healthcare. Indeed, Wall Street is the second most prevalent source of funding for healthcare, after internal reserves flowing from operating revenues.[6] However, most capital investment has been used to increase the bottom line in short-term, predictable, and low-risk ways that usually are related to building new facilities that provide high-margin, high-volume services. An example of investors' interest in HIT is instructive. The typical way of investing in HIT rewards the elements of the system that are known to be the money earners—and only those elements—often to the exclusion of funding the system in ways that would improve the quality of care and outcomes. The challenge is to make the case that systems designed to improve patient care and outcomes can add to shareholder value.

Hence, payment and investment are inexorably intertwined. As long as payments are tied to selected services, investment will focus on enabling the increased provision of those lucrative services. Some believe radical payment reform will be necessary to shift away from the current focus on volume to a focus on value. Such a shift should open up new streams of investments to build high-performing health systems capable of dramatically accelerating quality improvements. However, some key questions remain: Is the leap worth it for investors? Is it clear to them what is on the other side? What are the pathways to get to this new destination?

Defining Value

Economists emphasize the need to change the emphasis from volume to value and to base competition in the healthcare system on the outcomes that patients receive. By concentrating on the results of care rather than on the particular services that are delivered, the providers who deliver them, or the settings in which they are delivered, the alignment of incentives, payment, and coordination will occur to produce the best results.

For Elizabeth Teisberg, "creating competition [based] on value is the central challenge in healthcare reform."[7] Teisberg defines the first step in the transformation of competition in healthcare as the alignment of value with the delivery of care. To be truly "value based," a delivery system should possess the following characteristics:

- provide care that is focused on creating and improving value for patients, not simply on lowering costs;
- deliver healthcare that is organized around clinical conditions over the full cycle of care;
- measure and report value at the condition level; and
- align reimbursement with value and reward innovation.[8]

As Teisberg observes, central to the reorientation of the delivery of care is a focus on clinical conditions over the entire episode of care, rather than on individual encounters between the provider and the patient. An episode perspective on care, rather than one that focuses on discrete services, will require a reorganization of healthcare services around a shared knowledge base and accountability that is shared among multiple providers. A team approach to treating a health condition that continues across an entire episode of care requires fewer hand-offs to independent providers and lowers the likelihood of miscommunication that can lead to an undesired outcome. A team approach also can promote improvement in patient results across a care cycle or "service line," because it allows the entire team to learn and improve.

Migraine Care in Germany

A German health plan and hospital worked together to create a center that coordinates a patient's care for migraines. The first time a patient comes to the center with symptoms of a migraine, he or she is seen by a team that includes multiple clinical specialties and that develops a coordinated plan of care. In the first six months of the center's operation, the percentage of work days lost by patients who visited the center because of migraines fell from 57 to 11 percent, while the cost of care for this condition remained stable.[9]

Reluctance from Wall Street

Wall Street has a growing appreciation of the importance of improved infrastructure and quality improvement initiatives and a general sense that these contribute to better financial performance. However, investors often are impeded in hard-wiring quality into their investment calculus. Frederick Hessler, Managing Director, Healthcare Group for Citigroup, voiced three major concerns[10]:

1) the many contradictory voices on quality;
2) the difficulty in boiling down measures into a credible overall indicator of quality for a hospital or system; and
3) the lack of an apparent causal connection between quality and financial returns.

Citigroup recently conducted a survey of investors and found that investors *expect* improved margins from investments in quality.[11] Moody's Investor Service, a leading provider of research and financial information to capital markets, notes that a not-for-profit hospital's strategic focus on quality *can* translate into improved ratings through increased market share, operational efficiencies, the securing of better rates from payers, and an overall improved financial position.[12] But the reality today is that investment decisions rely mostly on traditional financial indicators, such as return on capital. In the absence of a known equation on the return on capital from investments in HIT, or quality improvement infrastructure, or value over an episode of care, this is unlikely to change.

The Importance of Scale and Integration

Scale is widely understood by investors to be a driver of favorable financial performance. Large-scale, high-revenue organizations are better positioned to succeed under uncertain economic conditions, including during periods of market volatility, during a recession, when under threat of losing tax exemptions, or during times of increasing capital constraints.[13] A recent Citigroup study observed a discernable difference between large, medium, and small organizations in financial results between 2001 and 2006. Larger organizations are advantaged by[14]:

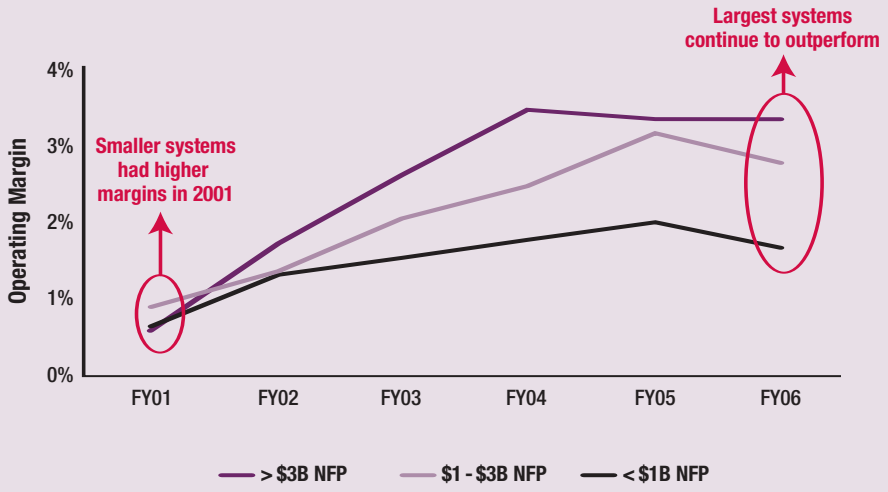
- greater operating margins;
- faster revenue growth;
- lowest supply costs;
- lowest bad debt;
- lowest cost of capital;
- better management of labor expense; and
- better capability to leverage information technology spending.

For example, health systems with revenues of of $3 billion or more have experienced higher margins than those with revenues of less than $3 billion between 2002 and 2006 (See Figure 1).[17]

The investor's view is that large organizations have a more strategic approach to capital spending, including new hospital acquisition, the funding of new initiatives or infrastructure, and investment in HIT and improving operations.[15] But do all types of large organizations perform equally well? Organizations can grow very large through horizontal accumulation or vertical integration. Horizontal accumulation includes combining similar organizations, such as with multiple hospitals. Vertical integration includes combining different types of organizations, such as hospitals, primary care facilities, and long-term care facilities. Investors have banked on both types of organizations in the past, with large hospital corporations on the one hand and integrated health networks (IHNs) on the other. However, these past investments have resulted in both boom and bust outcomes. Growth for growth's sake alone is viewed by investors with some skepticism.[16]

Many healthcare experts believe that integration is the key to improved delivery system performance in terms of financial and quality results. Citigroup compared the financial performance of IHNs with the previously discussed revenue size data and discovered that IHNs are consistently achieving above-average profitability. Indeed, the top 15 IHNs outperform the largest systems (more than $3 billion

FIGURE 1 Scale Has Led to Stronger Results



Source: Hessler F, "Does Quality Matter to Wall Street?"; May 15 2008.

FIGURE 2 Quality and Bond Ratings

Hospital with Bond ratings Ba1 and below were excluded from graph because of their small numbers (Ba1: n=6, Ba2 n=6, Ba3: n=4, B2: n=3, B3: n=1)

*CMS Core Measures Composite Score including congestive heart failure, pneumonia, acute myocardial infarction, and surgical care improvement program bundles.

Source: Allison J, "The Financial Implications of Clinical Excellence"; May 15, 2008.

revenues) by as much as 1 percentage point in operating margins.

Strengthening the Link

There is a growing body of evidence that larger, more sophisticated organizations outperform smaller, less organized practices and have critically important attributes, including physician collaboration, scale, and affiliation, that provide infrastructure support.[18] Additionally, there is some evidence that integrated medical groups provide higher-quality care than individual practice associations,[19] and health systems with more centralized infrastructure achieve higher quality.[20]

But are these improvements in quality associated with improved financial performance? According to a 2008 report by Moody's, bond ratings are higher for hospitals that perform better on measures included in "Hospital Compare."[21] The Baylor Health System leadership team conducted a similar analysis of the association between quality and bond ratings for more than 200 hospitals and found that higher-quality ratings are associated with higher bond ratings.[22] Hospitals with the highest bond ratings had a composite quality score of 89, which is 7 points higher than hospitals with the lowest bond rating (see Figure 2).[23]

The favorable bond rating affects an organization's ability to borrow money, which can then be invested in organizational supports that improve quality. Also, many hospitals have demonstrated significant savings from process improvements that have increased quality—for example, patient safety improvements.[24]

Meaningful Measurement

Wall Street is searching for the "Holy Grail" in quality measurement—*a summary measure* of the quality and value provided by a healthcare system. From an investor's perspective, if a handful of financial measures are widely recognized and used for financial management and investor decisions, why do similar quality-based

measures not exist? The reality today is that there are no widely acceptable summary measures of "whole system" performance.

A great deal of work is now under way to develop summary or composite measures of healthcare performance. Initially, this work has been focused on summary measures of quality as a first step toward moving to value. To date, the National Quality Forum (NQF) has endorsed a rich portfolio of measures applicable to health plans, hospitals, nursing homes, ambulatory practices, and other settings. Some have taken these measures and developed composite measures for specific conditions such as congestive heart care, acute heart attack, and pneumonia. Others are starting to combine these composite measures across conditions into an overall composite measure for a hospital.[25] Finally, researchers are aggregating the individual hospital's composite measures in a system into one "über" multihospital system composite measure.[26] The challenge moving forward will be to develop composite measures both for clinically integrated systems and composite measures that reflect quality (including patient outcomes) and cost. Needless to say, there are plentiful data and measurement challenges related to building such composites that must be met.

Wall Street insiders also admit that the many voices and sometimes seemingly contradicting views from the quality enterprise create confusion for the capital markets. For example, they mention the many efforts under way at the national and state levels and in the public and private sectors to measure and report on hospital infections; the expanding number of measures included in Hospital Compare; and the cacophony of approaches to payment alignment being pursued by public and private purchasers with very limited information available to date on their effects on a hospital's financial well-being. The bottom line for investors is that in lieu of the "Holy Grail" value measure, and a clear sense of how payment rewards higher value, it will be difficult to fully factor value into investment decisions.

The Path Forward

Investments in value can transform delivery systems for the better, but investors are cautious to take the leap because of the uncertainty and risk associated with new ways of doing business. Although this is a big challenge, a number of elements of the value equation are falling into place, and the pathway forward is being charted. These elements include measurement, payment, and accountable care systems.

Measurement of value requires measure sets that address patient outcomes, care processes, resource use, and patient engagement in decisionmaking over the episode of care.[27] To that end, NQF has developed a Comprehensive Measurement Framework for Patient-Focused Episodes to guide the development and endorsement of value-oriented standardized measures, and efforts are now under way to fill measure gaps.[28] In addition, the High-Value Health Care Through Better Information and Quality Improvement project at the Brookings Institution is providing a road map for the development of health information exchanges at the community level that aggregate data from multiple sources to provide performance information on patient-focused episodes.[29]

Innovations in payment that support a value orientation are emerging and include bundled payments for patient-focused episodes,[30] new forms of capitation,[31] next generation pay-for-performance programs that concentrate on intermediate outcomes,[32] and payment for delivery system innovations that fill the gaps in care, such as with the medical home.[33]

New systems of care are evolving that can implement organized processes for improving the quality and controlling the costs of care. Shortell has identified six models of "accountable care systems" that show promise to fulfill these new

"The bottom line is that quality care is cost-effective care."

–Joel Allison, President and CEO, Baylor Health System

"Trinity Health has made a sizable commitment to quality initiatives in 2000, investing $315 million in HIT infrastructure within its 44 hospitals. We have seen a 21% reduction in severity adjusted mortality rates, which translates into 2,600 saved lives per year. In addition, we've also seen a 60% reduction in medication errors attributed to bar coding, a 45% reduction in pressure ulcers, and a 46% reduction in liability costs. The total return on our initial investment to date is close to $81 million."

–Joe Swedish, President and CEO, Trinity Health

organizational requirements. These include multispecialty group practice, hospital medical staff organizations, physician-hospital organizations, interdependent practice organizations, health plan-provider organization/networks, and independent practice units.[34]

Conclusion

The transition from volume to value is under way, with promising developments in payment policy, delivery system design, performance measurement, and investor interest in banking on quality. Strong leadership is needed from both healthcare delivery systems and Wall Street to move U.S. healthcare from its emphasis on volume to one on value. To advance the value strategy for their organizations, trustees and senior management teams, who take a balanced view of the quality mission and financial results and commit to multiyear investment strategies in new models of care delivery, will advance the value strategy for their organizations. Increasingly, investors understand the contributions of quality investments toward long-term financial returns. And continuing an ongoing dialogue between investors and healthcare quality measurement leaders will help define a core set of quality and value measures that Wall Street can hardwire into its calculus of risk and return on investments in delivery systems.

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NQF's 2008 Leadership Colloquium

Achieving Value in Healthcare

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Does Quality Matter to Wall Street?

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The Financial Implications of Clinical Excellence

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