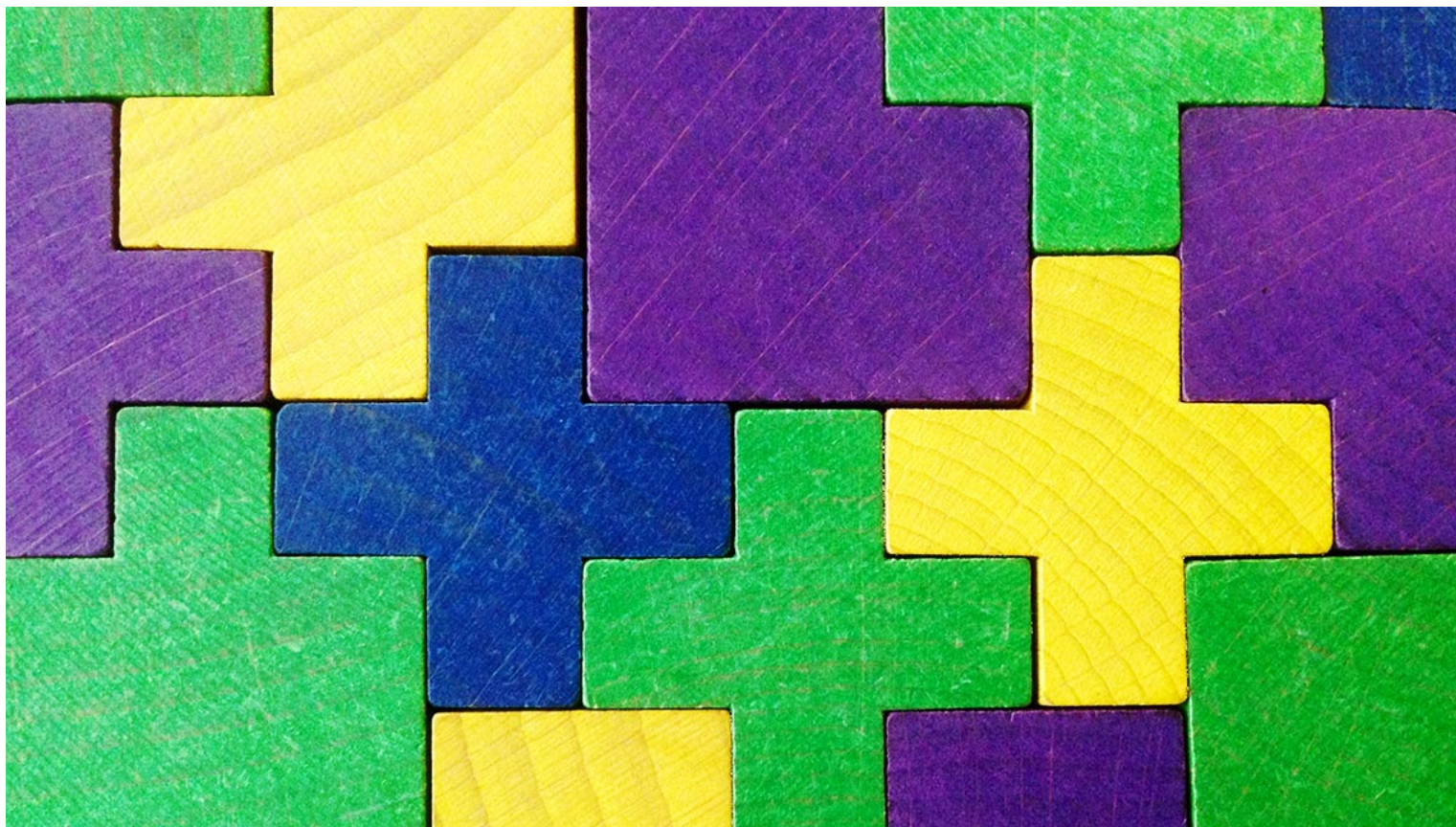


PERFORMANCE MEASUREMENT

3 Keys to Shifting How We Pay for Health Care

by [Todd Rothenhaus, MD](#) and [John Fox](#)

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In 1998, Ben Lecomte became the first person to swim across the Atlantic. It took him 73 days to complete the 3,716-mile journey. When asked how he managed each day to confront the vast ocean that lay ahead, he answered, “I never jump into the water thinking about the entire ocean, I just cut it into small pieces. When I am in the middle of the ocean, I think about being in a pool and the pool moves with me.”

These days, health care organizations find themselves crossing another ocean – from fee-for-service to fee-for-value. By 2018, declared the Department of Health and Human Services back in January, half of all Medicare payments will be tied to value. Today 80% of Medicare is still fee-for service. That’s a lot of open water to cover.

Accountable Care Organizations, or ACOs, are leading the effort to transform health care delivery in the U.S. In just five years, more than 700 ACOs have formed, providing care for 25 million people. But despite explosive growth and considerable promise, success has proved elusive for the vast majority of ACOs. In the first year, only a quarter received a bonus for hitting performance targets, while 11 failed the most basic test on quality scores. Recent results for 2014 show little improvement – less than one-third of ACOs received a payment.

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A collaboration of the editors of *Harvard Business Review* and the *New England Journal of Medicine*, exploring cutting-edge ways to improve quality and reduce waste.

In our work with ACOs, we’ve identified three general principles that can guide providers in their efforts to improve quality scores – all of which involve measurement. In 2013, the second year of the Pioneer ACO program, just two of these ACOs accounted for more than \$36 million in savings – close

to 40% of the entire program that year. How did they do it? Truth be told, these Massachusetts-based providers had the benefit of serving as the test kitchens for a handful of commercial risk-based contracts prior to entry into the CMS ACO programs, so they had a head start. Over the course of several years prior to joining the pioneer ACO program, and then continuing to the present, we have helped them develop capabilities that are relevant to any provider embarking on the fee-for-value journey.

Here are some lessons learned.

Start simple, and build as you go

It pays to start small and keep things simple — building capabilities, tweaking workflows and demonstrating success (including fiscal success) before expanding to other initiatives.

One ACO, for example, started with the goal of optimizing a single basic quality measure — in this case, HbA1c levels for patients with diabetes. (HbA1c provides a gauge of historic blood sugar levels.) To accomplish this, they first needed to build an open IT infrastructure to connect numerous clinical systems across their ACO just to report the data. Second, they needed to motivate providers to follow guidelines and monitor results. Finally, they needed to figure out how to reward providers for outcomes.

In the process of tackling just one quality measure, they managed to build new competencies and rally providers in a way that helped fuel subsequent efforts. With these capabilities in place, tackling new quality measures was markedly easier. While new ACO entrants may not have the luxury of managing to a single measure, they can still benefit from breaking down quality management into its component parts.

Focus on the “small picture”

It is often small decisions – whether made or deferred – that shape health care costs and quality. Our high performers trained their focus and technology on what behavioral economist Dan Ariely has called “the small picture” – the small decisions and behaviors that, additively, lead to big impacts.

One such small-picture decision our ACOs focused on is the choice to send patients out of network for care. Paying your competitors for patient care that you can deliver represents a hefty financial loss, especially if you can provide the same care at lower cost, and it’s particularly a shame if your quality is better. Of course, there are sometimes good reasons to send a patient out of network, such as when a particular specialist isn’t otherwise available. But, as a recent Harvard Medical School study showed, even in ACOs with a large number of specialists, patients still went out of network for 54% of specialty visits.

We helped tackle this problem through choice architecture by modifying the ordering screen of the providers’ electronic health record. When a provider looks for a referral, in-network specialists are now clearly flagged. While a referring provider is free to choose any specialist, if she does choose an out-of-network provider, she’s prompted to select a

reason for doing so from a drop-down menu. After making the in-network choice more visible and prompting providers to reflect on their decisions, the in-network ordering rate increased by 14%.

Measure and (creatively) reward the right behavior

Changing the behavior of large groups is never easy, but it's particularly hard in new organizations – as most ACOs are — that have yet to align around a shared sense of purpose and mission. And yet, the shift to value-based payment requires major behavioral shifts: A physician accustomed to cranking through 30 patient visits per day, for example, must become comfortable with spending an hour with a diabetic patient to prevent a readmission.

Of course, providers find it easier to get behind new approaches when they have skin in the game – especially upside. But money is only one tool to help get doctors rallied behind the cause. One of our ACO clients found that bringing patients to physician meetings to testify to the positive impact of new care models on their health helped motivate and align clinicians. Another ACO saw noticeable upticks in provider satisfaction when it started tracking and celebrating the number of patient lives saved under the program. At New England Quality Care Alliance, the not-for-profit physician network of Tufts Medical Center, physicians are able to reinvest shared savings back into their practices to fund innovations that ease the work burden on them and their staff while also improving patient experience. In each of these cases, the celebration of and reward for small victories along the way helped fuel long-term success.

The recent, sobering results of the Medicare ACO program reveal that population health is a long game that most health care organizations are not yet equipped to play. The reality is there is no quick and easy way to lower costs while improving quality. It's difficult, block-and-tackle work that takes time and patience. But by taking a steady, staged approach, sweating the details, and celebrating small victories along the way, organizations can survive, and even thrive through, the shift to value.

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