Moving from Volume to Value: Part 1

Are you prepared for the changing healthcare environment?

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Every physician has experienced the many changes in the past two decades that have altered the way we treat patients. Most physicians would agree that healthcare is becoming overwhelmingly complex. Just a few years ago, a primary care physician practiced alone or in a small group, with a small staff of one or two employees for each doctor, read one or two journals a month, only occasionally requested consultation from a specialist, went to the hospital and made rounds on his or her patients early in the morning and also late in the afternoon, and could complete the paperwork in about one hour a week. Those days of the solo practitioner or small group practices of primary care doctors are gone.

Today the healthcare environment is exceedingly complex and very difficult for nearly all physicians to navigate alone.

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For example, there are thousands of new drugs, treatments, and diagnostic tests, all of which require decision-making from the doctor, followed by achieving prior authorization approval from the payer before the patient can be prescribed a medication or have a test ordered. Each prior authorization can take 20 to 30 minutes to obtain. Computerization was supposed to make us more efficient but has resulted in the need to purchase expensive equipment, have IT support readily available, purchase expensive annual updates, and, in most cases, has led to a loss of productivity for physicians who have transitioned from paper charts to electronic medical records.

There is a steady erosion of reimbursements, rising overhead costs,

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and loss of income for most physicians. There are complex new regulations to follow, and acronyms are choking the desire and enthusiasm for many doctors to remain in healthcare. There is always the fear of litigation and the expensive malpractice premiums that we must incur. Is it any wonder that physicians are experiencing burnout in increasing numbers? It is not difficult to understand that the medical community is unable to reach consensus on what to do with the current health insurance situation.

In the past, the physician received compensation based on the services he or she had provided to his or her patients, the traditional fee-for-service (FFS) method of reimbursement. For those physicians who have opted to be employed physicians, their compensation is often the relative value unit (RVU) metric, which has a specific value for each billing code. The trend for the foreseeable future is to move from volume of care to value of care that we provide in outpatient treatment.

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What Is the Current Status of American Healthcare?

Almost 18% of the U.S. GDP is relegated to healthcare expenditures, which is unsustainable in the global market place. It is also of note that this very costly healthcare system does not come with a concomitant improvement in outcomes compared with Germany, England, Sweden, and Switzerland, which spend nearly 50% less than what Americans spend. Other Western countries also are struggling with healthcare costs. It is sophistry to believe that increased spending on healthcare will enhance or improve outcomes.

Aside from the challenges faced by individual physicians, the overall state of healthcare in the United States necessitates changing perspectives on providing care. Currently, healthcare accounts for nearly 18% of the nation's GDP, which is considerably higher compared with all other economically developed nations, where healthcare accounts for an average of 9% of their GDP.[1] We also spend about $9000 annually per capita. By comparison, countries such as Germany, France, and Canada average closer to $5,000 per capita.[1]

This high level of spending in the United States does not appear to significantly improve outcomes. In the United States, population health outcomes such as life expectancy and rates of chronic conditions are worse than in most other developed nations.[1] Whereas population health outcomes are only partially determined by healthcare, outcomes more closely related to care, such as rates of diabetes-related amputations, also are higher in the United States.[2] A study of our nation's healthcare system is a lesson in diminishing marginal returns—more spending has not equated to better health.

The fee-for-service model often results in over-utilization of low-value services and unnecessary care.

How Did We Get Here and Why Change Now?

What Are the Traditional Forces that Define and Shape the U.S. Healthcare System?

We have arrived at this point through a variety of forces that have traditionally shaped the healthcare system in this country. Healthcare in the United States is distinguished as a predominantly private, complex multi-payer system that has focused on scientific and technologic advances. Insured patients do not bear the full cost of their medical care, due to coverage often paid by the employer, and so patients have no incentive to consume less in the way of services, nor are their providers given any incentive not to provide more medical services. In addition, competing special interests from physicians, hospitals, insurers, the pharmaceutical industry, and patient advocacy groups have all worked to strengthen their position in the policy landscape, sometimes to the detriment of high-value care. Each of these components contributes to the higher costs seen in this country, with little accountability regarding quality or outcomes measured or rewarded.

Although the rate of healthcare growth has slowed somewhat in recent years,[3–5] it does not appear to have reached a ceiling. As more of the economy's resources are devoted to healthcare, less is available for other goods and services. Although jobs within the healthcare sector generally are higher-paying, if the overall growth of healthcare outpaces that of the rest of the economy, Americans will find themselves in the very near future less able to access and afford the care they need. American businesses also are faced with the burden of growing healthcare costs as they struggle to provide benefits to their employees and remain competitive internationally.[6] Not least pressing are concerns about the long-term solvency of public programs such as Medicare and Medicaid, because more expensive healthcare costs translate to higher taxes to cover these all-important programs.

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Why Do We Need to Change?

Physicians may not consider all of these matters on a day-to-day basis, but they do affect their ability to provide healthcare and shape the care that is delivered. The FFS model often results in overutilization of low-value and unnecessary care.[7] FFS also can impede coordination of care for patients across the healthcare system.[8] This service model does not appear to be sustainable, especially as the number of elderly people[9] and those with chronic and complex health needs[10,11] increases in the population. As long as providers are rewarded for the volume of care delivered, as in FFS arrangements, instead of for the value provided, they are pressured to deliver more care, much of which may be unnecessary, and population healthcare costs will continue to rise without regard to improvement in patient outcomes.

Both private and public payers of healthcare have recognized this and have begun to shift their payment models, which soon are going to be tied to outcomes.

Employers have recently started shifting costs to employees by requiring increased contributions to their premiums, higher deductibles, and the use of high-deductible health plans (HDHPs).[12] Enrollment in HDHPs currently consists of about to 29% of insured workers,[12] up from a mere 4% in 2006.[13] As more patients are enrolled in HDHPs and face the full cost for at least their initial care, these patients are more likely to demand transparency in costs, better results, and a clearer understanding of what they are getting for their increased payments.

Contingent upon changes with the current presidential administration, the Department of Health and Human Services is striving to have 90% of all Medicare FFS payments tied to quality or value by next year.[14] Medicare's new payment reform system, The Medicare Access and CHIP Reauthorization Act (MACRA), which goes into effect in 2018, will help the organization to reach that goal. MACRA consolidates previous quality reporting systems to streamline tracking and reporting, thus further encouraging value-based care over volume, or FFS. If previous policy changes are any indication, as Medicare goes, so too will private insurance, very quickly.

To this end, private insurers already have begun to experiment with alternatives to FFS reimbursement arrangements. The Affordable Care Act (ACA) further encouraged insurers to do so,[15] through initiatives such as the National Quality Strategy and the development of Accountable Care Organizations (ACOs). These organizations are increasing in number, and, regardless of the ACA's fate, private insurers will likely continue to pursue such alternatives, given the pressure they receive from employers and patients to rein in costs.

Indeed, whether physicians are ready for it or not, the time for change is here. Physicians who can demonstrate that they can adapt to new incentives by shaving costs while maintaining and improving their quality of care and their outcomes will be more competitive in the changing marketplace. The question then turns to how to measure success in the new environment of value-based care.

Improving processes of care matters for improving overall quality, but the value of care is defined on the outcomes achieved.

Why Is Quality Important, How Do We Define It, and What Should We Measure?

The importance of quality in healthcare may seem obvious. It is underscored by the Hippocratic Oath that physicians take to "non nocere" or "to do no harm." Poor quality of care can also mean higher costs—whether through providing unnecessary care that results in iatrogenic disease, or forgoing important preventive care that ultimately results in greater disease burden requiring more expensive medical care. Of course, quality matters to patients as well. Even though they may not always know how to assess quality, patients want to receive it. To this end, providers are likely to face competition based on the quality they provide. Who wants to go to a doctor with a one-star rating? But where would such a rating come from and what would it actually mean? As the forces at play continue to transition incentives from volume to value, quality of care also will increasingly be tied to provider payment, and properly measuring quality will be primary.

Defining quality in healthcare is not a simple task, in part because quality holds different meaning to different stakeholders[16] and is multi-dimensional in nature. However, the widely used Institute of Medicine (IOM) definition of quality encapsulates a broad understanding of quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[17] This definition can easily apply to multiple perspectives, from providers to patients, to insurers to purchasers. The IOM further specifies that high-quality care should be safe, effective, patient-centered, timely, efficient, and equitable.[18]

However, as with anything of this magnitude, the devil is in the details. The IOM definition can serve as a guiding force, but how it will actually be applied in practice is what matters to providers. The Donabedian model, which serves as the primary framework for most quality metrics, partitions quality of care into three measurable components: structure, process, and outcomes.[19] Structural measures refer to capabilities of an organization or provider, such as availability of electronic records. Process measures are activities carried out by providers, and often stem

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from clinical guidelines. The rate of providing retinal examinations for diabetes patients would be an example. Outcomes measures refer to the health state of patients as a result of their care and includes measures such as mortality rates, lab values, or patient functional status.

The three components are connected, as structure drives process, which in turn drives outcomes. Quality assessments largely rely on process measures because they are easiest to track and record. In fact, 182 of the 271 quality measures available to report through MACRA are process measures. Improving processes of care matters for improving overall quality, but the value of care is based on the outcomes achieved.[20] The shift to value in healthcare will require utilizing outcome measures that stakeholders can agree upon for their ability to adequately capture the quality of care that matters to patients, physicians, and payers alike.

How Will We Improve Outcomes?

Proper measurement is the first step to improve outcomes. Tracking how patients fare can be achieved largely through electronic medical records. Before outcomes can be improved, providers first must know where they stand. Many physicians over-estimate their performance on quality measures until they are provided with their performance data.[21] To this end, continuous feedback on improvement also must be available to providers. From this feedback, payers can reward providers not only for achieving specific quality standards, but also for incremental improvements. By providing ongoing feedback for progressively better results, instead of continuing to penalize for not meeting a benchmark, providers may be encouraged to find innovative ways to improve.

Because outcome measurements are the road map toward improving outcomes, they will continue to be relied upon as quality measures, but when they are tied to incentives, they have to be clearly shown to improve outcomes. Porter, et al.[22,23] are proponents of organizing care and assessing quality by condition, rather than by procedure, so that the complete spectrum of a patient's health needs is more fully considered by the providers who care for them. Bundled payments are another approach to reducing costs, as is incentivizing coordination of care across providers and specialties. Although bundled and capitated payments are not new to healthcare, new tactics can help avoid the pitfalls of previous attempts to curb costs.

Other approaches to improve quality include public reporting

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of outcomes, although research is mixed on the effectiveness of this method.[24,25] If patients can see how providers stand next to their peers, it may promote competition to improve quality. One of the problems with this method is that providers may find ways to game the measurement process. Also, even with clear definitions of measures, patients may still not know how to best prioritize them. Therefore, outcome measures that are important to patients will be an important consideration moving forward. Continuous improvement can be attained if we:

Outcome measures that are important to patients will be an important consideration moving forward.

- Continuously assess and revise metrics to accurately reflect quality that matters to stakeholders;
- Assess whether process measures continue to reflect outcomes accurately;
- Revise standards and clinical practice guidelines concurrent with new evidence;
- Promote a learning atmosphere that is less punitive and more encouraging of success;
- Promote effective communication within and between organizations;
- Maintain and improve IT systems to accurately and efficiently capture care and outcomes; and
- Use outcomes that are easiest to track and difficult to manipulate.

Bottom Line

The healthcare profession is about to undergo radical changes. No longer will volume of patients seen or services provided be the metric for payment and reimbursement. Providers, payers, patients, and the government will have to make a big adjustment by moving from volume to value. We believe that the success of a medical practice is going to depend on the speed at which the healthcare profession can make this transition. **PM**

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