



## Getting to value in high-value health care

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HARVARD





+ We have a “value” problem



$$\text{Value} = \frac{\text{Quality}}{\text{Costs}}$$



## Quality is suboptimal



- 1 in 4 seniors injured during hospitalization\*
- Each year:
  - 1.8 million hospital-acquired infections
  - 1.5 million preventable injuries due to medications
- Large variations in use of effective services
- Patient experience often suboptimal

\*Source: OIG, HHS, Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries

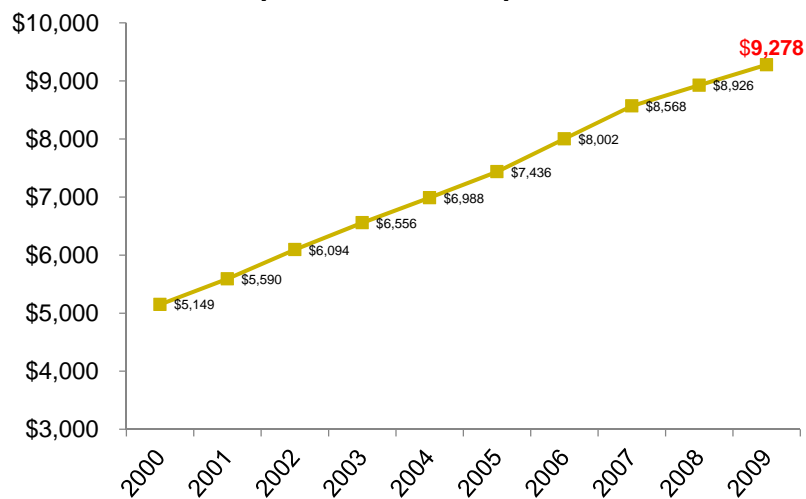


$$\text{Value} = \frac{\text{Quality}}{\text{Costs}}$$

## + Massachusetts Healthcare Spending

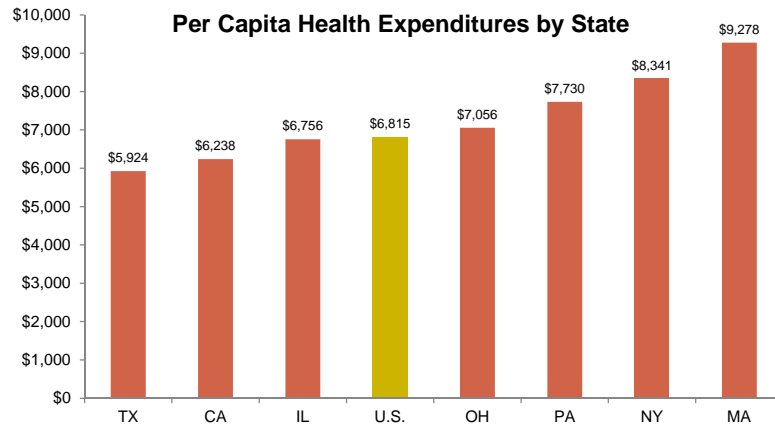


Per Capita MA Health Expenditures



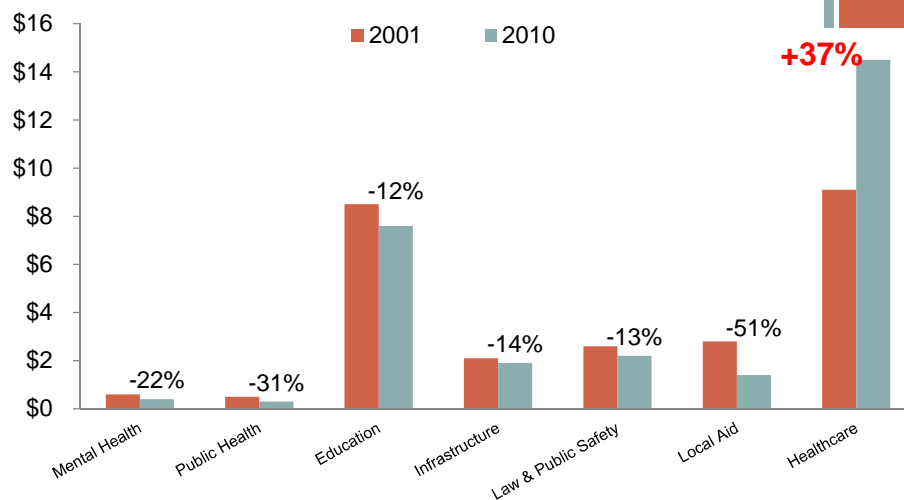
Source: Centers for Medicare & Medicaid Services

## + MA healthcare compared to others



Source: Centers for Medicare & Medicaid Services

## + The cost of high cost healthcare



Changes in Massachusetts state spending, 2001-2010 (in billions)

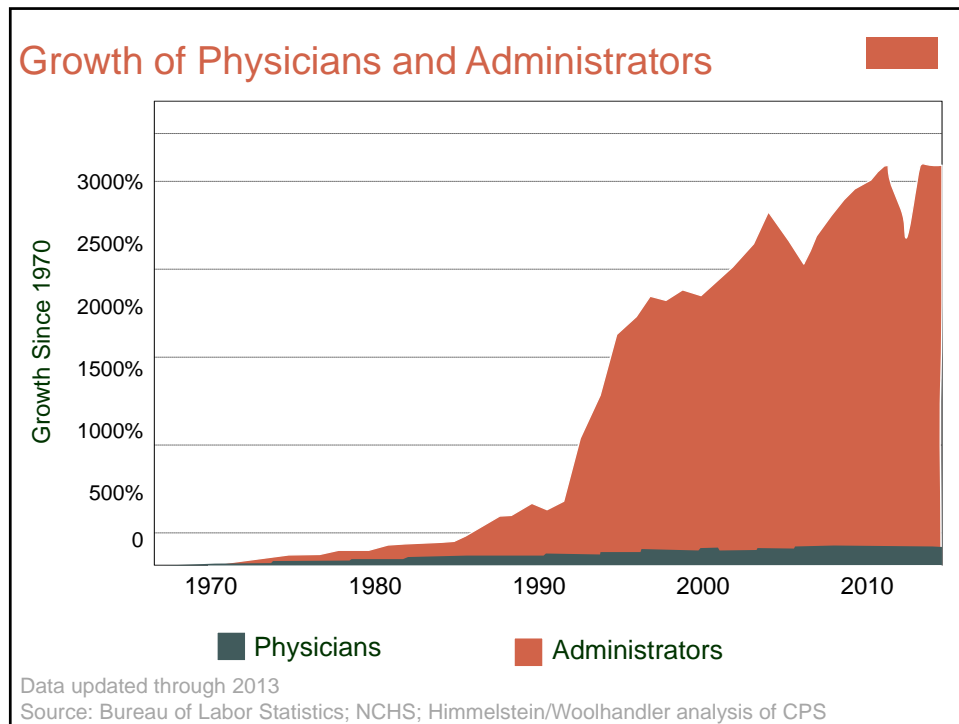


+ Why do we have a value problem?



+ What do policymakers think?

- Pay providers incorrectly (FFS, incentives)
- Providers inadequately focused on evidence
- Leads to:
  - Over-use
  - Fragmentation



+ What is the ACA doing?

## + The ACA & Improving Value

### ■ Change how we pay for things

- Hospital readmissions reduction program
- Value-based purchasing
- PQRS → MIPS

### ■ Hold providers accountable

- Patient-centered medical home
- Accountable Care Organizations

### ■ Federal support for innovation

- CMMI

+ So is the ACA working?







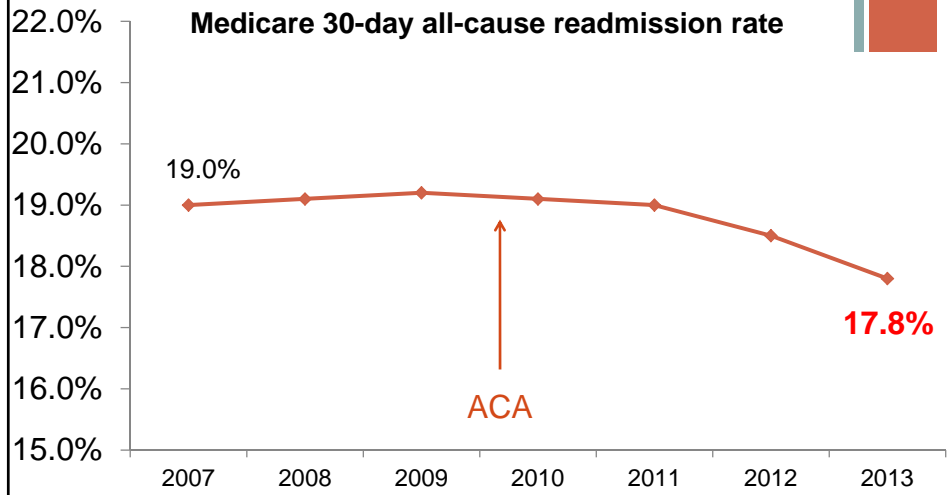
## + What are the facts?

### + Readmissions reduction program



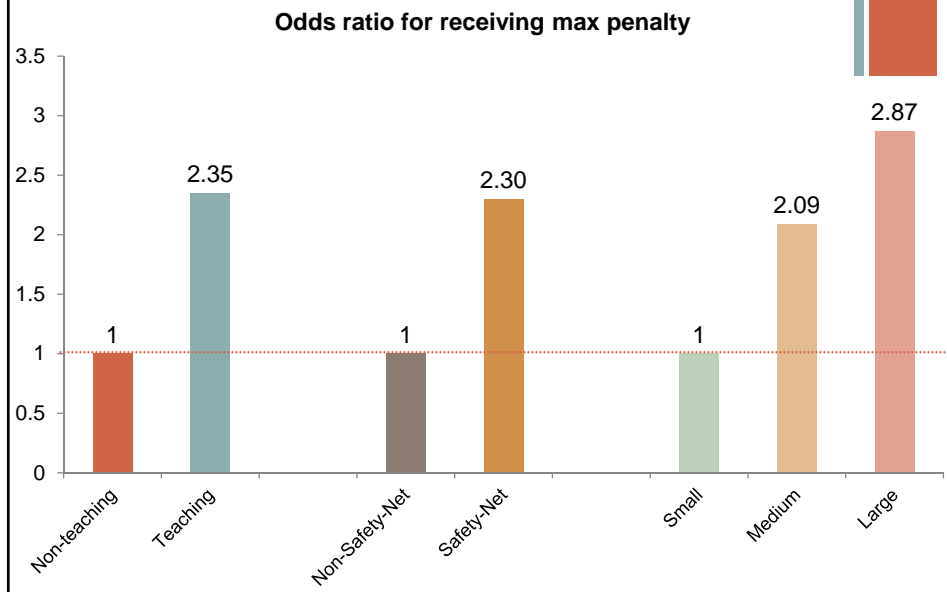
- Up to 3% penalty for high readmission rate
- Initially focused on medical conditions
- Recently added surgical ones

### + Good News: Readmissions are down

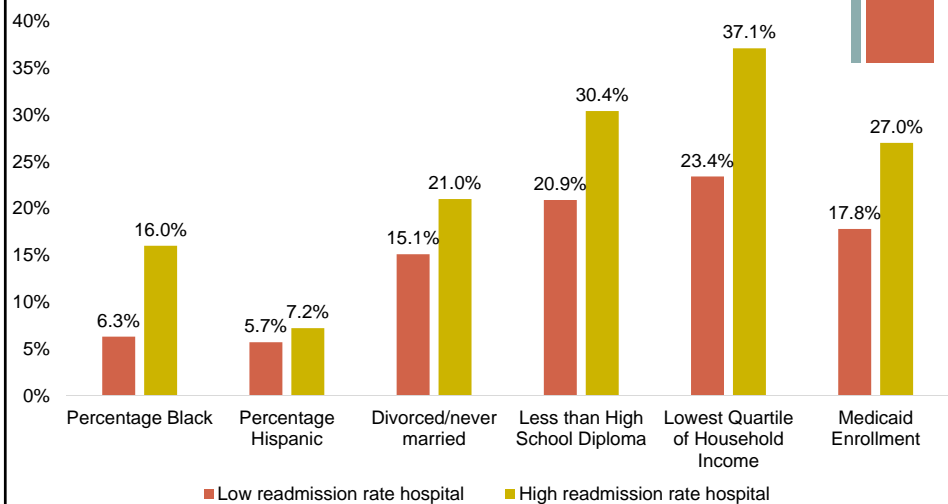


Source: Centers for Medicare & Medicaid Services

### + Which hospitals are getting the penalties?

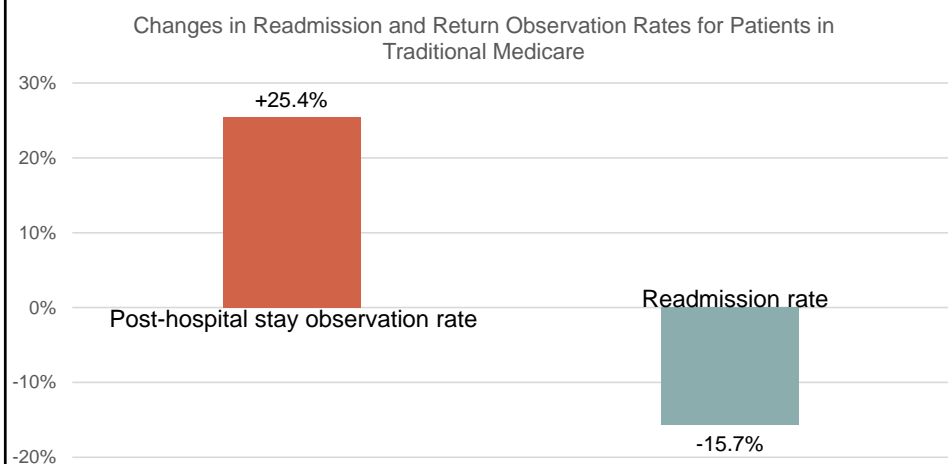


### + Which hospitals are getting the penalties?



Barnett et al., JAMA IM 2015

### + Substituting obs for readmissions?

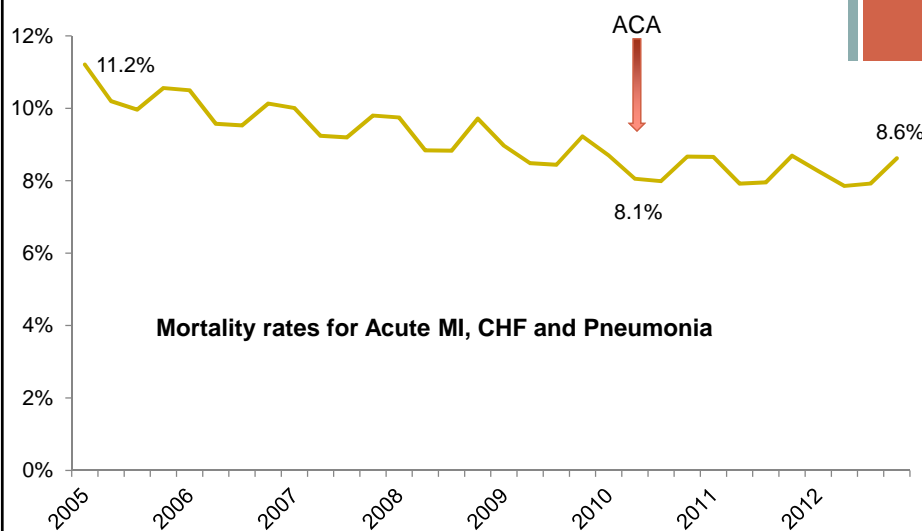


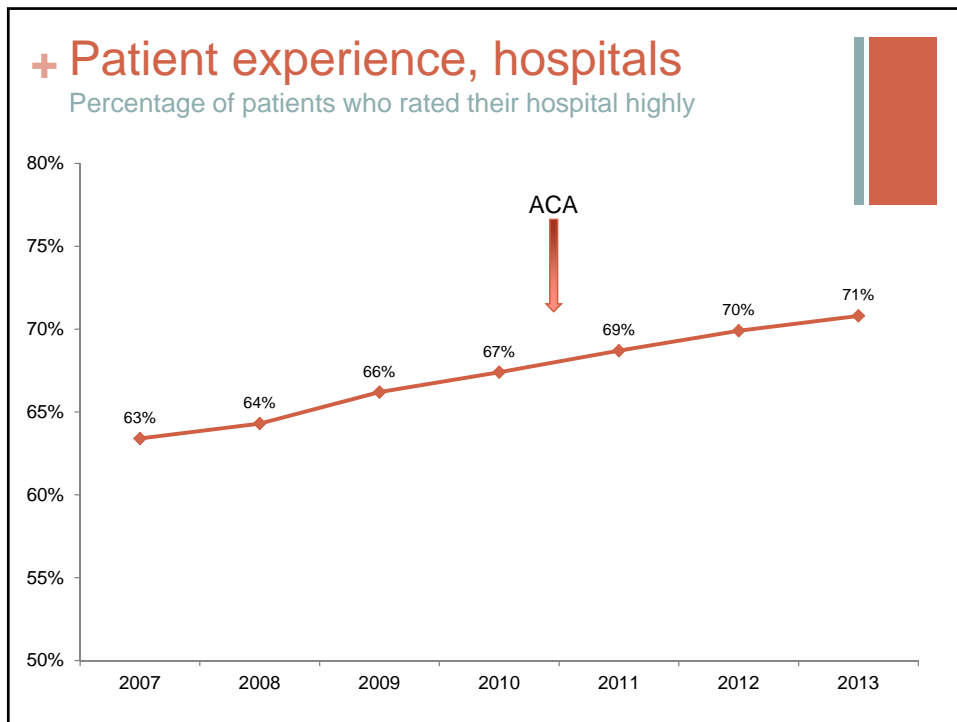
Noel-Miller and Lind, Health Affairs Blog 2015

## + Value-based purchasing aka P4P

- Up to 2% of Medicare payments tied to:
- Broad set of quality measures:
  - Processes
  - Outcomes
  - Patient Experience
  - Efficiency

## + Mortality rate for VBP conditions



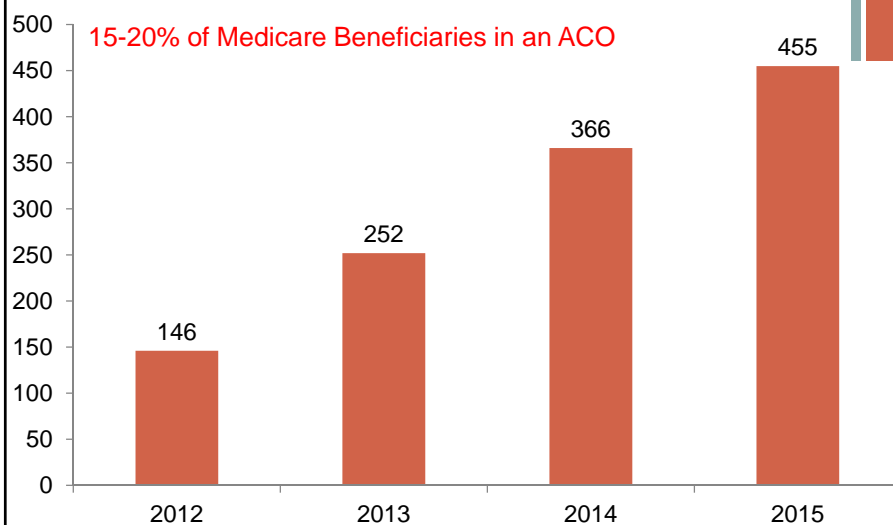


**+ What's happening with ACOs?**

## + ACOs: What are they?

- CMS Definition: “ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve”
- Simple Definition:
  - **Group of providers** that take **responsibility** for a **population**

## + Good News: Number of ACOs up



Source: Health Affairs Blog; Centers for Medicare & Medicaid Services

## + Less clear: impact on C&Q

- Flavor #1: Pioneers
  - 32 Pioneers initially signed up
  - Net savings 1.2% after the first year
  - 13 have since dropped out or switched to SSP
- Flavor #2: Shared Savings:
  - Little evidence of impact on savings
- Impact on health? Equivocal
- Early Days

## + Summary of our journey

- Transitioning to paying for “value”
- Some progress on aligning incentives
- But are we doing it right?

+ 6% of Medicare payments to hospitals now tied to “value”

## + National Measures, Weights

Yours may vary

Measure		Weight
Readmissions reduction		3.0%
Hospital Acquired Conditions		1.0%
Value-based purchasing	Mortality	0.6%
	Patient experience	0.6%
	Processes of care	0.4%
	Efficiency	0.4%



## Massachusetts HRR hospitals

Total Medicare payment adjustment (VBP, HRRP, & HAC)

Hospital	Total adjustment
Baystate Mary Lane Hospital	+0.62%
Emerson Hospital	+0.28%
Newton-Wellesley Hospital	+0.20%
St. Elizabeth's Medical Center	-1.87%
Boston Medical Center	-1.92%
Tufts Medical Center	-2.10%

+ So is this really “value”?

## + How do we get to better value?

- Begin to measure what matters:
  - Key safety indicators (e.g. diagnostic errors?)
  - Patient reported outcomes
  - Patient health and well-being
  - Functional status
- Think about focusing on change

## + Example: Priorities of frail, older pts

- Maximize physical comfort
- Avoid delirium
- Receive treatment at home
- Meaningfully interact with family and friends
- Maintain maximum possible independence
- Reduce burden on family caregivers



+ So are we measuring what matters?



## + Current approach to value

- Strengths:
  - Focusing on evidence-based standards
  - Some degree of focus on outcomes
- Shortcomings:
  - Technical
    - Measures are deeply flawed (coding, etc.)
  - Social/Humanistic
    - Value is about values
    - Priorities determined in DC
    - One size fits all
    - Fails to measure so much of what matters

## + A strategy for getting to value

- A broader, more robust measurement effort
  - Use the EHR
  - Use more patient-elicited measures
- Measure what matters
- Pay for quality, but..
- Let patients and providers drive value agenda
  - Make meaningful data widely available
  - Help patients drive the incentives

+ “Health care payers have concluded that medicine is too important to be left to physicians alone”



+ What can we do?



## + Shaping the value agenda


- Engage in leadership roles
- Put the patient at the center of the conversation
  - Tell stories
- Make your voice heard
  - Write
  - Speak
  - Engage

## + Summary: Value-based care

- Long journey towards higher value healthcare
- Things have never been better
- Things could be so much better
- Value is about values
  - And yours are likely different than mine
  - And mine are different from mine
- Understanding that is our next step



Questions?

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