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Preparing for a value based economy

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Lecture objectives: at the conclusion of this lecture the participant will gain an understanding of the definition of value in healthcare and how this definition applies to Anesthesiology. The economics of enhancing «value» in anesthesiology will be examined to include the impact of current governmental programs on reimbursements, an examination of newer payment models, the economic impact of enhanced recovery initiatives and the contributions of the perioperative surgical home. Finally, the participant will integrate the time-tested general principles of performance, value and economic gain in the context of a changing and stressed healthcare system.

Syllabus: all agree that healthcare reform in the United States is inevitable. There is less agreement on what the end product of this reform might look like or how we will get there. The complexities involved in changing the US healthcare system are as complex as any in a society. No one group can mandate reform actions (look at the challenges of implementing and now deconstructing the Patient Protection and Affordable Care Act (*Obamacare*!). Hence, reform will come about through fits and starts, a hodgepodge of programs, and an uneven application across geographic and practice boundaries. If one assumes that this drive towards «quality» and «value» are inevitable, then one must ask what will be the economic consequences of this effort.

WHAT IS VALUE?

This is a broadly applied term to commodities and services. In healthcare, the commonly published definition is:

Value = (clinical outcomes + patient experience)/total cost *per capita*

Practicing anesthesiologists are as concerned with providing value by this definition as any other clinician. Our efforts individually and collectively at improving clinical outcomes, enhancing the patient experience and doing this at the lowest possible per capita cost is in our best interest.

DOES «VALUE» PAY?

This is an entirely different question and requires some analysis. The question is: Pay for whom? A second question might be: Who is paying? These are not trivial questions. In a strict fee-for service model, in the broadest of healthcare paradigms, the more you do, the more one is paid. Quality has no impact on annual income. Of course this is not strictly true, as poor clinicians risk market completion for services, reduction in referrals, loss of privileges, and potential malpractice liabilities for poor clinical outcomes. But there are no doubts that within the bounds of reasonable care (not the «best care»), the more you do, the more you make.

Anesthesiology is distinctly different from other disciplines of Medicine and Surgery in that our care is largely narrow in focus and directed towards specific problems or episodes of care (i.e. the patient needs a hip replacement). In other areas, there are greater opportunities for poor coordination of care, excessive testing, unnecessary consultation and the like, which do little to add to quality and do much to increase cost. Nonetheless, in a value-based world, will anesthesiologists fair better or worse economically? Put simply, will our reimbursement go up or down if we hop on board the «value» train?

WHAT ARE OUR CURRENT VALUE METRICS AND DO THESE PAY?

Anesthesiology struggles in finding appropriate value metrics. The Physician Quality Reporting System (PQRS) is a

program developed in 2007 and administered by the Centers for Medicare & Medicaid Services (CMS). The self-reported quality measures used in the PQRS system form the basis of incentive payments from CMS for Medicare part-B fee-for service activities. In 2015, there was a 1.5% reduction in payments for those not participating in the program. For anesthesiologists, the suggested reporting measures include antibiotic timing, temperature management and central line insertion management. The struggle in our profession revolves around the reporting or process measures (how we do things) versus outcome measures (what is the result of our activities). Fortunately, anesthesiology is increasingly safe and poor patient outcomes are rare. Unfortunately, for the regulatory perspective, this makes finding appropriate outcome measures difficult.

WHAT ARE VALUE-BASED PAYMENTS?

Value based payments are administered through CMS and starting in 2015 apply to physician groups of 100 or more. These payments will use the PQRS measures and apply a total cost overlay to the population. Those groups who demonstrate high quality and lower cost stand to gain financially whereas those who are poor quality and high cist will have payments withheld.

WHAT CAN ANESTHESIOLOGISTS DO TO ENHANCE PAYMENT IN A VALUE SYSTEM?

The answer to this question is manifold. Three specific areas include participation in the Perioperative Surgical Home model, enhanced recovery after surgery initiatives, and old-fashioned «customer service».

The perioperative surgical home model is a proposal by the ASA to formalize much of our activities to include comprehensive care of the surgical patient from the time the decision is made for surgery until sometime after surgery is completed. The concept is that we can provide the best opportunity for coordinated care before, during and after surgery, thereby enhancing value. The economics of this proposition are untested. One can imagine that anesthesiologists are in an ideal position for much of this work; however, we are poorly positioned for other aspects of this work. Our current economic models largely revolve around intraoperative care of the patient. Certainly, physicians practicing critical care medicine and those in pain medicine have other sources of income, but in larger groups, the bulk of revenue remains in intraoperative care. There is no good proposal for how reimbursements might work should anesthesiologists take more active roles in preoperative and postoperative, hospital based coordination services. Some posit that the real value is to the overall system, and thereby this service renders the anesthesiologists «invaluable» as a physician team member in the value based payment scheme.

Enhanced recovery after surgery (ERAS) programs provide true value. There are increasing reports of improved clinical outcomes (i.e. return to function, infections & etc.), enhanced patient experience (i.e. reduced PONV), and reduced cost (i.e. reductions in LOS) for patients in ERAS programs. In our hospital at UNC we initiated an ERAS program for major abdominal surgery and our initial findings show a better patient experience, reduced complications and reduction of 1.6 days resulting in a reduction in charges of over $2,000,000. This reduction in LOS enhances the physician and hospital bottom line by allowing more patients access to the facility (assuming there are cases available) while at the same time reducing an individual's expense. This is a complete winner.

Finally, one must never forget that «value» is more than simple economics and extends to the customer's perception of service rendered. In Anesthesiology we have many customers to include our patients (forgive me for equating the two terms), the surgeons, our hospital partners, physician colleagues, perioperative nursing and on and on. By establishing best practices that optimize clinical outcomes, enhance the patient experience and reduce cost, we will truly be viewed as contributing «value» in the organization. This process starts with our ability to communicate effectively and build relationships among all of our patients, customers and partners. Attending meetings, participating on committees, volunteering in the community and so on are all associated with enhanced revenues indirectly.

IN CLOSING

Does «value» pay? In my opinion the answer is clear: value always pays. Failure to participate in value based initiatives result in reduced reimbursements and finally, an inability to be perceived as valuable by your patients, partners and colleagues will directly result in lost contracts and opportunities for increased business.