Value from the Patients' and Payers' Perspectives

Joshua H. Atkins, MD, PhD[a], Lee A. Fleisher, MD, FACC, FAHA[b,*]

KEYWORDS

• Value • Quality • Cost • Perioperative • Patient-reported outcome measures • Perspective • Patient

KEY POINTS

- Value incorporates both quality and costs.
- The value components incorporated in the determination of quality and costs depend on the perspective taken, for example, payer and patient.
- Although major morbidity and mortality are important determinants of quality, the patient perspective must include return to baseline function and quality of life.

The costs of health care continue to increase in the United States and most of the industrialized world. Despite the increasing costs of care, the outcomes achieved have remained unchanged for decades. Michael Porter and colleagues[1] propose that the overarching strategy for health care should be to improve value for patients, whereby value is defined as patient outcomes achieved in relation to the amount of money spent. Further, they think that "only through achieving better outcomes that matter to patients, reducing the costs required to deliver those outcomes, or both can medicine unite the interests of all key stakeholders."

Value within the paradigm of anesthetic care is difficult to separate from that of the entire perioperative experience. The US federal government has developed the value-based payment plan that began as bonuses on physician reporting of specific metrics to more recently imposing penalties for not reporting. The Centers for Medicare and Medicaid Services (CMS) also incorporated these measures into hospital-based payments, and most hospitals incorporated these metrics as part of their contracts with physicians. The initial focus by both the CMS and the American Society of Anesthesiologists for anesthesiologist metrics was process measures, evidence-based processes of care that are linked to outcomes. These initial metrics included some

[a] Department of Anesthesiology and Critical Care, Perelman School of Medicine of the University of Pennsylvania, Philadelphia, PA 19104, USA; [b] Perelman School of Medicine of the University of Pennsylvania, Philadelphia, PA 19104, USA
* Corresponding author. University of Pennsylvania, 3400 Spruce Street Dulles 680, Philadelphia, PA 19104.
E-mail address: lee.fleisher@Uphs.upenn.edu

Anesthesiology Clin 33 (2015) 651–658
http://dx.doi.org/10.1016/j.anclin.2015.07.001 **anesthesiology.theclinics.com**
1932-2275/15/$ – see front matter

of the Surgical Care Improvement Project measures, such as antibiotic timing within 1 hour of incision and choice of antibiotic for surgery. These measures were also incorporated into private plans like Blue Cross/Blue Shield with physicians and hospitals.

The other major change in the payment area has been the move to bundled care. Although slow to be adopted, Sylvia Burwell,[2] Secretary of Health and Human Services, has recently written that the federal government's plan is to accelerate the movement to alternative payment models, including bundled payments, over the next 3 years. Bundled care involves paying a single amount to hospitals that includes the payments for both hospital and physician care. It frequently also incorporates payment for care for a time frame after hospital discharge that can vary from 30 days to 90 days. The premise of such a payment approach is that the hospitals will take responsibility for delivering the highest quality care for the lowest total cost (ie, value). Although the Accountable Care Organization model linking provider payments to quality and outcomes has recently demonstrated national cost savings,[3] the barriers to implementation of bundled payments may be substantial.[4] This article focuses on the value equation from the perspective of the payer and patients.

VALUE FROM THE PAYERS' PERSPECTIVE

Currently, the method to judge the outcome side of the value equation is complex and varies according the group using the data. Death is an easily assessed outcome, and risk-adjusted mortality can be measured and used in the value equation. Risk-adjusted complication rates can also be used by the payers to assess value; however, complications increase costs and must be incorporated into the cost side of the equation as a function of resource utilization. Furthermore, each surgical procedure or medical treatment would require a defined set of outcomes, which require risk adjustment. For example, risk-adjusted outcomes have been well defined in the Society of Thoracic Surgeons (STS); but this has required decades of research and a great deal of resources to collect in their database.[5] Defining similar risk-adjusted outcomes across the broad spectrum of surgery and interventional procedures would be a substantial undertaking. Other surgical specialty groups, including anesthesiologists, have or are developing databases to demonstrate value. These databases include the National Anesthesia Core Outcome Registry established by the American Society of Anesthesiologists National Quality Institute and the Multicenter Perioperative Outcomes Group established by Kevin Tremper and the University of Michigan.[6,7]

In the United States, there is a burgeoning growth of quality metrics that can be used on the quality side of the equation. These quality metrics can be defined by the specialty itself, such as the STS risk-adjusted mortality and complications, or by the payers, such as private insurers or Medicare. Initially many of the measures were oriented around process, but there is increasing pressure to focus on outcomes. In order to truly measure quality of care for patients, even from the payers' perspective, quality metrics must be focused on outcomes.

Patrick Conway[8], the chief medical officer of the CMS, has articulated the following goals of performance measurement (**Table 1**).[9]

- Meaningful quality measures increasingly need to transition away from setting-specific, narrow snapshots.
- Reorient and align measures around patient-centered outcomes that span across settings.
- Measures need to be based on patient-centered episodes of care.
- Capture measurement at 3 main levels (ie, individual clinician, group/facility, population/community).