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Orthopaedic Healthcare Worldwide

Improving Value in Healthcare

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The United States (US) healthcare system faces daunting challenges in the years ahead. Increasing costs, limitations in access to care, and variability in the quality of care delivered threaten the long-term viability of the system. Many factors contribute to the financial pressures plaguing the US healthcare system, including an aging population, a fragmented delivery and payment system, defensive medicine, advances in technology, and discordant incentives between the people who deliver and utilize healthcare services and the entities that pay for it. However, a primary driver of dysfunction in healthcare in the United States is a lack of emphasis on value.

Value in healthcare, as in any industry, can be defined by a ratio of the benefits accrued and the dollars spent to achieve those benefits [6]. Benefits in healthcare include both the quality and patient experience associated with the provision of healthcare services. Currently, our healthcare payment and delivery systems are value-agnostic. Providers are incentivized based on the volume and intensity of healthcare services they provide to their patients, with little emphasis on or motivation to maximize outcomes and control costs. Patients who utilize healthcare services have little or no skin in the game, with very little direct responsibility for the cost of the care they consume and almost no information available to them regarding the cost or quality of care delivery by the providers from whom they seek care.

These trends have led to calls for multistakeholder collaboration to improve quality and reduce the cost of healthcare, and to increase transparency regarding the cost and quality of healthcare services. As a result, a number of payment and delivery reforms have recently emerged, which attempt to promote higher value healthcare. Many of these reforms have particular relevance to the field of orthopaedic surgery. Musculoskeletal care is a major driver of healthcare services utilization

Note from the Editor-in-Chief: *We are pleased to introduce readers of* Clinical Orthopaedics and Related Research® *to Orthopaedic Healthcare Worldwide, a new quarterly column. This section explores the political, social, and economic issues associated with delivering musculoskeletal care in the many environments in which our specialty is practiced, both in the US and around the world. We welcome reader feedback on all of our columns and articles; please send your comments to eic@clinOrthop.org.*

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and spending in the United States. Despite the well-documented benefits of musculoskeletal care in improving quality of life and function in patients who have musculoskeletal ailments, wide variations in utilization rates, quality, and cost of care persist. As a result, orthopaedics has proven to be an ideal testing ground for value-based payment reforms, such as episodes of care or "bundled" payments; value-based delivery reforms, such as accountable care organizations (ACOs); and the development of patient registries to collect and report valuable information that could be used by patients, providers, and payers to inform medical decision making and payment policy. Implicit in these reforms is a shift in emphasis from volume to value in healthcare.

The rationale for episode-of-care payments and ACOs is simple [1–5, 7]. Our healthcare system is highly fragmented, and our delivery and payment systems are not set up to promote coordination of care across providers to optimize patient outcomes and experiences and minimize costs. Furthermore, the current legal and regulatory environment in the United States, including Stark laws, anti-kickback provisions, civil monetary penalties, and US tax law, make it difficult or even illegal for providers to collaborate in ways that would facilitate a more coordinated, high-value experience for their patients.

Both episode-of-care payments and ACOs require providers to accept greater risks than they are accustomed to under traditional fee-for-service payment models. However, providers should be reassured that the risks assumed by providers in value-based payments and delivery systems can be defined as "performance risks," rather than the "insurance risk" associated with traditional capitated payment models and managed care delivery systems. In other words, providers accept risks for factors that they can directly influence, including the quality and cost of care they provide for their patients; not for factors that are outside of their control, such as the baseline health and comorbidities of the population of patients they treat.

Before engaging in value-based payments and delivery systems, providers should first assess the goals, motives, capabilities, and limitations of their organizations. If the primary goal is to maximize profits or to capitalize on perceived vulnerabilities in the payment and delivery systems, it is unlikely that success, if achieved, will be sustained. Long-term success is predicated on the creation of patient-centric value creation (eg, higher quality, patient-centered care at a lower cost). Providers should also assess their risk tolerances and organizational cultures. Achieving success in value-based payment and delivery requires an organizational culture that emphasizes and facilitates high-quality, safe, patient-centered, cost-effective care. It also requires strong physician leadership and a willingness to change often longstanding practice patterns and systems of care. Finally, organizations should define in advance the metrics they will use to evaluate and monitor successes or failures.

In order to facilitate high-quality, effective, patient-centered, and efficient healthcare, providers, patients, payors, and policymakers all need access to relevant data that can be used to inform clinical, payment, and policy decision-making. These data need to be made transparent and available in real-time to those who need it. They also need to be relevant to the care being provided, appropriately risk-adjusted, actionable, and understandable to those who use it. For providers, this means access to real-time data regarding their adherence to evidence-based processes of care, patient experiences, patient outcomes, and efficiency or overall costs of care. Provider organizations, including physicians and hospitals, must be willing to move past denial and criticisms of the methodologies used to collect and report the data, and instead begin to use the data to change their practice patterns and improve the overall value of care they provide. And for patients and purchasers of healthcare services, this means increased transparency of

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information regarding the costs and quality of healthcare services delivered by providers. Patient registries, such as the American Joint Replacement Registry (AJRR), offer valuable tools in our quest to aggregate relevant information regarding hip and knee replacement surgeries. With time, the information contained in the AJRR could serve as a useful resource for patients, providers, payers, and policymakers to inform decision-making, improve outcomes, and reduce costs for these potentially life-altering procedures.

In summary, the US healthcare system is in the midst of transformational change. Current trends in healthcare spending are unsustainable, and as a result, it is likely that our healthcare delivery and payment systems will change dramatically over the next decade. As providers of valuable, quality-of-life enhancing services, orthopaedic surgeons are well-positioned to play pivotal roles in the conversion of our healthcare system from one that is focused on the volume and intensity of services provided to one that incentivizes high value, patient-centered care.

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