Health Policy Newsletter

Volume 18 Number 1 **March, 2005** **Article 1**

From the Editor

The Value of Value-based Purchasing

David B. Nash, MD, MBA*

* Thomas Jefferson University

Suggested Citation:
Nash DB. From the editor: The value of value-based purchasing. Health Policy Newsletter 2005; 18(1): Article 1. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol18/iss1/1.

From the Editor

The Value of Value-based Purchasing

Many of our readers are no doubt aware of recent national newspaper headlines trumpeting "Bribing Hospitals to do Better,"[1] "Employers to Pay Bonuses to Good Doctors,"[2] and related stories. Astute readers of the medical literature have probably seen terms like "Bridges to Excellence"[3] and "Rewarding Results"[4] representing a clever blend of public and private efforts to extend the early gains of value-based purchasing. Even foreign nations like the United Kingdom have transformed their delivery system to reflect an unprecedented nationwide payment-for-performance initiative.[5] What exactly do these headlines, national programs and overseas harbingers mean? Because value-based purchasing is such a broad, complex and controversial topic, I will limit the discussion here to a brief review of the research evidence, an update on recent progress, and a concentration on the future prospects and challenges inherent in such a system.

First, some definitions – value-based purchasing, pay-for-performance or quality-based purchasing are related concepts. It is clear that dramatic deficiencies in the quality of care delivered in the United States have been widely documented.6 Indeed, aspects of this dilemma have been discussed in this space before.[7] For our purposes, value-based purchasing is defined as "payment or reputational strategies aimed at providers that individual employers, employer coalitions or government programs could plausibly adopt to stimulate the improvement of quality in healthcare."[8] There appear to be different types of value-based purchasing extant in the marketplace, including programs with funds going from the government to hospitals, employers to health plans, and even health plans to hospitals and individual physicians. We simply don't have space to evaluate all aspects of this fascinating recent development, but current evidence suggests that nearly a hundred individual performance-based purchasing programs have been documented with varying degrees of success and heterogeneous designs.[9]

The research evidence underlying value-based purchasing has recently been thoroughly reviewed by the Agency for Healthcare Research and Quality (AHRQ) in their report entitled, *Strategies to Support Quality-based Purchasing: A Review of the Evidence*.[8] In the executive summary accompanying this comprehensive AHRQ report, the researchers note that because quality-based purchasing is in its infancy, their first objective was to develop a conceptual model of how these strategies could be used to create incentives for providers to improve care. The second objective was to identify all the published, peer-reviewed, randomized, controlled trials of quality-based purchasing and to summarize what was known about their relative effectiveness. Finally, they sought to determine whether these outcome reports convey meaningful information or are too influenced by chance events to be useful. Indeed, a broad undertaking by whatever measure!

The AHRQ researchers concluded that there is some evidence that both payment and reputational incentives can work but "to date there is little unequivocal data on which to base quality-based purchasing strategy selection."[8] In other words, despite the broad spectrum appeal and the logic behind paying more for better performers, the

early returns are decidedly mixed. I believe Steinberg was right when he said, "The challenge, therefore, is not to demonstrate that there already is a business case for quality improvement in healthcare, rather it is to establish new incentives that will create such a case."[10]

What of recent progress around the nation given the somewhat shaky research foundation just alluded to? Value-based purchasing has taken on an urgency in the marketplace not seen previously, due in no small part to an acceleration in the overall costs of healthcare, most especially the drug and hospital components. Again, a detailed discussion of all of the various models would be burdensome. Let me concentrate, then, on some recent research from our own Department of Health Policy.

From a review that our team conducted of the published literature on value-based purchasing, six key strategies used by the purchaser community emerged.[11] By focusing on the purchaser community, we can attempt to better understand the concept of value-based purchasing. The six strategies include: 1) collecting information and data on the quality of care provided by health plans and providers, 2) selective contracting with high quality plans or providers, 3) partnering with plans or providers to improve quality, 4) promoting so-called Six Sigma quality in industry-based models for minimizing errors and waste, 5) educating consumers on the many aspects of quality, and 6) rewarding or penalizing providers through a mixture of financial incentives or disincentives. Our work (based on a nationwide survey of purchasers in addition to the literature review) has contributed to the national conversation about the appropriate mixture of tools and techniques to accomplish value-based purchasing.

Given the somewhat flimsy research basis and our assessment of the market place, what are some of the current and future challenges facing those involved in value-based purchasing? Here is where the story gets very interesting! Among the many challenges ahead for both purchasers and physicians include aspects of the following six challenges. First, "efforts to motivate doctors will have minimal effect unless the purchasers or insurers promoting incentive programs represent a substantial proportion of a physician's practice or unless different purchasers and insurers in the same geographic area coordinate programs."[12] Simply put, we need to have enough skin in the game to make it worth our while to effect dramatic structural changes in what we do every day.

The second challenge is in the design and implementation of these programs and getting the right mix of criteria for quality. We could quibble endlessly about which measures are appropriate given the scores of research validated indicators now readily available in the marketplace.

The third challenge involves the possibility that we may "unfairly penalize physicians caring for patients who are at a socioeconomic disadvantage and may motivate the physicians to reduce the number of patients for whom they provide care." Epstein[12] worries that rewards for quality could therefore help make the rich richer and the poor poorer.

The fourth challenge involves the different mindset by what we mean when we say "a healthy purchaser." Generally, a healthy company relates to a healthy financial position or so-called bottom line. Some of our leading researchers believe that a healthy company of the future may take on a different context relating more to

measurable health indices of the employers.[13] Perhaps, a new partnership-based healthcare strategy is necessary for employers integrating health into the very culture of the business and encouraging and enabling thoughtful use of resources for the future.

The fifth challenge is the perceived risk that we may be creating a two-class healthcare system. Physicians achieving the highest scores could become an elite class that charges more for their services. This may drive up overall costs and limit access for patients unable to pay the price. Also, in this two-class health system, is the concern about what society ought to do with those physicians or provider groups with consistently lower quality scores. Should we mandate remedial continuing medical education, changes in recertification or the actual credentialing process at hospitals and other systems?

The sixth challenge is one of the cost and reliability of the quality measurement process itself. Without a widespread adoption of computerized medical records and their linkage back to legacy systems, we may not be able to effect broad-based adoption of value-based purchasing. For example, using an estimate of $30 to $50 to abstract a chart by hand and an average of 50 charts per physician, annual data collection costs in the absence of an electronic medical record could easily amount to $2,500 per physician. In a metropolitan area like Philadelphia, total collection costs for the data alone could run easily to the millions of dollars.

Given the aforementioned six challenges, is all lost then and should we abandon value-based purchasing pilot projects across the country? Certainly not! In my view, value-based purchasing represents a watershed in the quality measurement and improvement movement in our nation. I am confident of our ability to create research proven valid and reliable measures that will help us guide reimbursement decision making. Physician leadership in this process will be crucial to help us avoid some of the treacherous currents flowing around the aforementioned challenges.

In that spirit, I am very proud of Jefferson Medical College and, particularly, the Department of Health Policy. Our early work with the Commonwealth Fund in New York City and our Issue Brief, *How Does Quality Enter into Healthcare Purchasing Decisions*,[11] has been cited as one of the most important healthcare projects emanating from the Commonwealth Fund in the last two years. In addition, with our colleagues at the National Business Coalition on Health in Washington, D.C., and the Healthcare 21 Business Coalition in Knoxville, Tennessee, we have launched a nationwide program entitled, "The College for Advanced Management of Health Benefits." The college was created to help employee benefit managers meet the growing challenges of providing high quality health benefits and managing rising benefit costs. According to our marketing brochure,[14] the college offers "a practical intensive program that focuses on benefits purchasing techniques and skills that emphasize improving the value, quality cost ratio, and effectiveness of healthcare services purchased on behalf of employees." In a nutshell, we are bringing to bear our research knowledge into a focused hands-on training program for the actual purchasers of medical care.

We have a new book in the works to be published later this year entitled, *Closing the Quality Chasm*, published by Jones and Bartlett. This book will summarize many aspects of our work on value-based purchasing and provide the reader with one-stop shopping about these and related quality of care issues. Finally, the focus of our 11th Annual Summer Seminar on July 15, 2005, will be on value-based purchasing.

No doubt, there are many skeptics among our readers regarding the ***value*** of value-based purchasing. After all, the research evidence is muddied and physician autonomy, once again, appears to be on the chopping block. I, for one, am confident that our own work coupled with many of our colleagues around the nation and those directly involved in programmatic development will convincingly demonstrate to the skeptics that getting paid more for doing a better job is an exciting and fruitful public policy we can all collective embrace. As usual, I am interested in your views and you can reach me at my e-mail address david.nash@jefferson.edu.

References

1. McGinley L. Bribing hospitals to do better. *WSJ*. May 27, 2003, B1.

2. Anonymous. Employers to pay bonuses to good doctors. *NY Times*. April 10, 2003.

3. www.bridgestoexcellence.org, accessed 12/2/04.

4. www.leapfroggroup.org/RewardingResults, accessed 12/2/04

5. Roland M. Linking physicians' pay to the quality of care – a major experiment in the United Kingdom. *N Engl J Med*. 2004;351:1448-1454.

6. McGlynn EA, Asch SM, Adam J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348:2635-45.

7. Nash DB. Report on report cards. *Health Policy Newsletter* editorial May 1998.

8. Dudley RA, Frolich A, Robinowitz DL, et al. Strategies to support quality-based purchasing: a review of the evidence. Technical Review 10, AHRQ Pub. No. 04-P024, Rockville, MD 2004.

9. Anonymous. Performance-based programs gain ground, offer 'real-dollars' to providers. *Performance Improvement Advisor*, March 2004.

10. Steinberg EP. Improving the quality of care – can we practice what we preach? *N Engl J Med*. 2003;348:2681-2683.

11. Goldfarb NI, Maio V, Carter CT, Pizzi L, Nash DB. How does quality enter into health care purchasing decisions? The Commonwealth Fund, Issue Brief May 2003, New York City, NY.

12. Epstein AM, Lee TH, Harnel MB. Paying physicians for high-quality care. *N Engl J Med*. 2004;350:406-410.

13. Berry LL, Mirabito AM, Berwick DM. A health care agenda for business. MIT Sloan Mgmt Rev, Summer 2004.

14. www.jefferson.edu/DHP accessed Nov. 23, 2004.