Value-based Healthcare

Value-based Healthcare: Person-centered Measurement: Focusing on the Three C's

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The Centers for Medicare & Medicaid Services' decision to tie 50% of traditional fee-for-service payments to quality measures through alternative payment models by the end of 2018 has accelerated the movement towards value-based payments and measurements [1]. Though value, defined as meaningful outcomes achieved for a patient rela-

tive to the money spent on his or her care [5], is generally measured after care, outcomes measured during care are often the most illuminating, providing a critical and full understanding of the benefits achieved—including the patient's experience [6].

Ideally, clinicians would track and analyze a patient's current status and trends to guide clinical decisions, shared clinical decision-making, and process improvement. The opportunity to track the trends throughout care can offer tremendous insight to clinical teams on what is working and when changes in care processes should be considered. Patient-reported outcomes (PROs) can be measured during and after care, thereby linking measurement to the fundamental reasons for seeking healthcare, rather than measuring proxies for quality [7]; they also

can provide standardized measures for improvement, offer discrete targets and goals, encourage patient engagement, and, most importantly, evaluate what matters most to patients—function and the ability to participate in daily activities.

Many quality-improvement initiatives focus on collecting process-data metrics to inform improvement. The American Heart Association urges providers to aim for a door-to-needle time of less than 60 minutes for the administration of tissue plasminogen activator in acute ischemic stroke. The American Joint Replacement Registry captures the frequency of choosing cephalosporins (the preferred antibiotic choice in the absence of severe allergy), as well as use of deep vein thrombosis/pulmonary embolism prophylaxis. While these measurements help us determine whether providers adhere to evidence-based guidelines, they do not tell us whether these processes help patients achieve their goals of pain relief and independent function.

We propose focusing on the essential measures of healthcare quality that are priorities to patients in their quality of life and dignity of death: Capability, Comfort, and Calm. Developed as a way to measure outcomes for chronic, long-term, and end-of-life conditions

A note from the Editor-in-Chief:

We are pleased to present to readers of Clinical Orthopaedics and Related Research® the next installment of Value-based Healthcare. This column explores strategies to enhancing the value of musculoskeletal care, improving health outcomes, and reducing the overall cost of care delivery. We welcome reader feedback on all of our columns and articles; please send your comments to eic@clinorthop.org.

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[8], these categories measure the benefits of care, not just satisfaction with the service. For care that lasts for the rest of a patient's life, measures of outcomes during care are obviously critical to understanding the value of healthcare and gaining insight on how to improve that value. For acute care and shorter episodes of treatment, these categories redefine how patients and their clinical teams identify success in the healthcare experience, beyond documenting processes and hospitality. Measures of capability, comfort, and calm are consistent with both patients' reasons for seeking care and clinicians' professional identities.

Capability measures a patient's functional status. Comfort measures relief from physical and emotional pain. Calm measures the extent to which patients can continue their life during care by considering elements like how many hours per week the patient spends scheduling and traveling to appointments, or how many hours are devoted to understanding and paying medical bills. The three C's encompass not only the gains from effective, caring treatment, but also the burdens of suffering, the disruptions of life, and the stresses of coordinating and receiving healthcare. Healthcare, like electricity, is an intermediate good—people don't really want to experience electricity, they just want it to work. Similarly, people want better

health, but most would prefer to have the results without the pain and inconvenience of the care experience. In this important way, healthcare differs from services where people are customers for the experience itself, such as luxury hotels, restaurants, or theme parks. Rather, people want the results of better health and want the experience to be good if they need treatment, but generally would prefer to minimize the experience. Put in this context, it is critical to ask about level of function, relief from suffering, and disruption of life, not just patient satisfaction, during and after care.

However, collecting the important measures without creating survey fatigue for patients or clinicians is challenging. While numerous validated PRO instruments can paint a detailed picture of a patient's pain and function, many of these are cumbersome to administer and still more cumbersome to complete as a patient. We suggest using smaller question sets such as the HOOS, Jr. [4] and the KOOS, Jr. [3] at more frequent intervals, reserving the longer tools for the pre-operative visit and at specified postoperative intervals (such as 2, 5, and 10 years after surgery). Using multiple measurement tools provides a path toward validating or improving upon the current measurement sets.

In implementing measurement tools, we must be mindful that patient-specific

goals and personal situations are not captured by most standardized patient surveys. Thus including some open ended questions is important both to identify improvements to the measures and to support the patient-physician relationship. Even patients presenting for an acute problem with an easily identifiable etiology may have other factors that could hinder recovery. Personalized, open-ended questions such as "How else can we be helpful?" or "What would enable you to return to your normal activities sooner?" or "How could we make this plan more workable to help you?" may draw attention to topics not previously considered. By asking open-ended questions, clinicians will be able to elucidate and respond to the important issues a patient might raise. Of course these questions don't replace the human interaction that forms the core of a gratifying patient-provider relationship, but having the answers also included in the survey enables patterns to be identified so that the care process or the measurement of it can rapidly evolve to reflect issues raised repeatedly. While not everything may be easily resolved, patients need to know they are heard. Healthcare professionals are trained to seek answers and provide solutions, but sometimes the most important response is validation or empathy. This is easily achieved in person, and may be further conveyed through a followup phone call.

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Part of improving person-centered health is bringing patients into the embrace of a healthcare team rather than the hectic experience of managing referrals to different specialists. For example, patients with lower extremity joint pain should work with co-located, interdisciplinary teams in condition-specific integrated-practice units (IPUs) to holistically support a patient's needs and improve health outcomes consistent with their goals, preferences, and values [2].

A musculoskeletal IPU should administer measures to understand global health (including emotional health), function, and pain at the first visit. Throughout the care cycle, it is important to collect condition-specific measures to understand Capability and Comfort, while working to determine the best questions to ask to understand Calm. Parsimonious measures such as “how far did you walk today?” and “are you able to complete your daily care plan?” can be easily collected, and both the level and trend of responses give clear and actionable information about how well the patient is doing. Provider teams can incorporate input from focused working groups, clinician consensus, and patient experience groups to refine the survey instruments so that they measure what matters to patients.

Meaningful, person-centered measurement is essential to drive improvement in healthcare value for patients. While good clinicians always ask patients how they are doing, often they are forced to measure things far less relevant to their real professional success with patients. Measuring what we seek to improve is a powerful source of insight and feedback. Knowing the level of function, relief from pain and stress, and ability to participate in daily life that our patients achieve also supports the professionalism of physicians and other care team members engaged in the calling of medicine. While thousands of process measures have been implemented in the past two decades, the joy of medicine and the success of patients are reflected in the positive outcomes of a patient's care—capability, comfort, and calm.

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