The Dream of Value-Based Care

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I had the privilege of delivering the plenary address at the third annual KLAS Keystone Summit in 2016, which was held outside Salt Lake City, UT. As many readers may know, KLAS is an organization that is focused on evaluating and grading vendors in the health information technology (HIT) marketplace. KLAS holds an annual event that brings together vendors and customers on neutral territory to improve the quality of offerings in the healthcare marketplace. Admittedly, this is an unusual methodology, and I was asked to set the intellectual table for this important event that was focused on population health. What follows is an edited version of my plenary address.

“Thank you for the opportunity to address this amazing group of vendors and customers today. I am not a technical expert. As a result, I’m going to cover 4 major topics, including a quick review of some of the barriers to achieving value-based care, an overview of the current healthcare landscape, a deep dive into some strategic and tactical challenges, and finally, I hope to give you ‘Nash’s vision of the future.’ I will do this by using a couple of personal stories and citing some relevant literature.

Let me bring you back to June 1981, more than 35 years ago. I’m sitting in the auditorium at the University of Rochester School of Medicine and Dentistry, happily awaiting my commencement ceremony. I vividly remember that our speaker was the leader of the US National Library of Medicine, but regretfully, I can’t remember his name. He delivered a captivating talk about the future of technology in healthcare. He said that each of us would have something called a ‘computer’ on our desk at work, and with this computer, we would be able to type messages to one another and to our patients, and finally, we would have all of the world’s medical knowledge on it, obviating further memorization (which we had spent 4 years working on in medical school). It was an amazing message.

In the conclusion of his speech, the US National Library of Medicine leader said that all of this would occur by the year 2000! Well, colleagues, here we are, 16 years later, and certainly several aspects of this vision have indeed come to fruition, but we have not made all the progress that was part of the dream in 1981. Why is that so?

Several key stumbling blocks and potholes exist on the road to implementing the 1981 vision. The most important stumbling block is the poor evidentiary basis of our work. Researchers recognize that approximately 20% of the time, we have evidence from randomized controlled clinical trials to support our decision-making. In other words, approximately 80% of the time we are practicing the ‘art of medicine.’ That art of medicine, extant since Maimonides, is now readily recognized as a source of waste and error.

Second, unexplained clinical variation and its attendant waste is a major cultural problem, completely baked into our current healthcare system. Physicians do what they’re trained to do, and in the absence of closure of the feedback loop, I find it difficult to see how we will overcome this critical limitation in our work together.

Third, it is undeniable that recent evidence continues to demonstrate that medical error is the third leading cause of death in the United States, despite the 1999 publication of the Institute of Medicine report, To Err Is Human: Building a Safer Health System.

Finally, as we attempt to create truly clinically integrated delivery networks, we’ve fallen considerably short of our ability to guarantee that a patient will receive the same high level of care in one component of the healthcare system as they will in another component of that system. We have not been able to ‘standardize’ our approach to the best available evidence, and to deliver, on a consistent basis, high-quality, error-free care.

These 4 stumbling blocks will not be overcome simply with the implementation of an electronic medical record (EMR) system.

With regard to the current industry landscape, I believe that the notion of Meaningful Use and the physician adoption and implementation of an EMR system has come a long way toward creating what my colleague, Brett Davis from Deloitte, calls ‘a level 1 business intelligence platform.’ In other words, although it’s important that physicians have an EMR system, this is just the beginning of the road toward innovation and improvement in patient outcomes.

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An EMR system without the capability of interactive questioning adds to the complexity and the lack of care coordination. Finally, an EMR system in a region without an effective health information exchange is nothing more than an electronic digitized chart. Ashish Kumar Jha and colleagues have shown that this is particularly concerning in that the total number of successful health information exchanges has declined from 119 to 106 in the past 5 years alone.4

What are some of the broader strategic and tactical challenges that the HIT industry faces in 2016? I agree with our colleague, Peter Pronovost, who calls for an alignment of learning laboratories, whereby clinicians will play a more comprehensive role in the usability and the interpretability of HIT tools.5 Pronovost and his team believe that clinicians must be more deeply involved in the evolution of tools within the HIT industry.

What may the future look like? Let me tell you a second story. I have given up inpatient medicine (nearly 8 years ago) when I became Dean of the Jefferson College of Population Health. I still see a modest number of ambulatory patients in our primary care general internal medicine practice.

Here is my vision for the future. Typically, I’m in examination rooms 23 and 24. My question is ‘what is occurring in examination rooms on either side of rooms 23 and 24?’ Well, one may answer that the same thing that’s happening in rooms 23 and 24 is also happening on either side of rooms 23 and 24. My colleagues are doing pretty much the same thing I’m doing. But here is the scary reality. In 30 years of ambulatory practice, I have never received timely, nonpunitive, evidence-based, severity-adjusted feedback on my performance relative to a local peer group, or in comparison to a national benchmark. Hence, I believe that a robust registry function that will help me to answer the question, ‘how am I doing?’ is going to be a major advancement in our field. I hope I’m around as a primary care physician to see this vision take shape.

Finally, I’m confident that as part of my future vision, we are witnessing the ascendency of a new member of the C-suite within the healthcare delivery system, namely, the Chief Population Health Officer. Working with Rita Numerof and her colleagues, we have completed multiple national surveys about the emergence of this new role.6 Among the many challenges facing the future Chief Population Health Officer are the need for accountable governance structure that is focused beyond the 4 walls of the hospital, the implementation of the Medicare Access and CHIP Reauthorization Act, alternative payment model and Merit-Based Incentive Payment System, better recognition of the social determinants of health, realization that postacute care is a complete ‘black box’ today, and finally, a brave new world of patient engagement with millennials who will never tolerate the kinds of silly delays and waste of time that their parents have endured for decades.

I want to thank all the leaders from KLAS, and especially the vendors that are here today. I salute all the vendors for your unique contributions, your entrepreneurial spirit, and your ever-evolving corporate vision. We are indeed lucky to be in this amazing business together, and to be citizens of the greatest country in the world.7

Well, there you have it. I’m happy to say that my remarks were very well-received, based on all the face-to-face feedback and related postconference communication. As always, I’m interested in your view as to how we may realize the dream of value-based care. You can reach me via e-mail at david.nash@jefferson.edu. ■

References