Prioritizing High-Value, Equitable Care After the COVID-19 Shutdown: An Opportunity for a Healthcare Renaissance

Reshma Gupta, MD, MSHPM[1]*, Lisa A Simpson, MB BCh, MPH[2], Daniel J Morgan, MD, MS[3,4]

[1]University of California Health, University of California Davis Medical Center, Sacramento, California; [2]AcademyHealth, Washington, District of Columbia; [3]Department of Epidemiology and Public Health, University of Maryland School of Medicine, Baltimore, Maryland; [4]VA Maryland Healthcare System, Baltimore, Maryland.

The day after Memorial Day 2020 marked an important transition in the United States' experience with coronavirus disease 2019 (COVID-19), with many states making initial plans to reopen. Alongside this reopening process, the US healthcare system needed to reopen to provide needed care to communities. This reopening, however, was in the context of several months of staggering financial losses for many medical centers that expected a larger surge than occurred locally and lost profit because of delayed elective procedures, all amid a national economic recession. Each medical center also faced a persistent risk of infection and a call for social equity as each one decided how to reopen. These decisions balanced the risks of reopening from COVID-19 exposure with patients' medical needs and the healthcare industry's financial needs.

This year's widespread healthcare closures were necessary to reduce COVID-19 transmission and prepare for a future patient surge, but these closures had unintended consequences. Nearly half of adults polled said they or someone in their household had foregone or delayed care since the outbreak began.[1] This was especially true for visits to emergency departments and doctors' offices for strokes, heart attacks, and routine medical care.[2] In a survey across 49 states, only 7% of primary care practices considered scheduling preventive visits as a high priority.[3] Eleven percent of polled adults reported delaying care worsened their condition,[1] and in hard-hit areas such as New York City, non-COVID mortality was 22% higher than expected.[4]

Avoidance of the medical system decreased not only use of necessary, high-value care but also use of low-value care. Low-value services are those in which the "potential for harms exceed the potential benefits,"[5] such as unnecessary hospitalizations, avoidable emergency department or clinic visits, unwarranted or excessive diagnostic testing (eg, annual physicals), and certain procedures (eg, spinal fusion surgery for low-back pain). Low-value care is costly, with $75.7 to $101.2 billion of the gross domestic product (GDP) spent on overuse.[6] This care risks contributing to financial and, in turn, clinical harm for patients because the average health plan deductible exceeds a typical family's available savings[7] and 25% of Americans say they have foregone treatment for a serious medical condition in the past year because of these costs.[8] Medical centers' significant financial losses are a sobering reminder of how much our system relies on fee-for-service billing that encourages high-margin profitable services regardless of necessity.[9] We must avoid quick reactions of increasing these procedures to respond to the sudden financial loses.

Medical centers across the country are choosing how to "reboot"—either deliberately changing how services are organized and delivered or returning to prior practices. Medical centers are facing potential for their own Renaissance in transitioning their organizations to modern healthcare delivery. In the 15th century AD, after experiencing the bubonic plague, Europe similarly transitioned toward modernity and great social change. Through the initial pandemic wave, we learned that even the largest health system could change their practices rapidly. COVID-19 achieved in 8 weeks what years of research, policy initiatives (eg, *Choosing Wisely*®, RightCare, Less Is More), and emphasizing value in reimbursement could not: stopping the delivery of a wide range of low-value services. We share three lessons learned from medical centers that have begun reopening services that can help us to better ensure higher-value, more affordable care that meets patients' needs.

KEEP PATIENTS CENTRAL IN REOPENING SERVICES TO DELIVER HIGH-VALUE CARE

Medical centers can better focus on high-value care by defining their high-risk patient populations; high-value treatments, procedures, and preventive care; and phases of reopening. During the first pandemic wave, medical centers tried to reassure patients about emergency care, such as coming in for chest pain or neurologic symptoms, through personal outreach and media campaigns. Outpatient virtual visits also continued, including primary care, specialty services, mental health treatment, and physical therapy. While reopening, some medical centers have assessed disparities by relying on their data analytics and, if available, embedded health services researchers to understand what care was stopped and what populations were most affected.

The University of California health systems, for example, had a learning collaborative focused on sharing methods to restore care delivery that prioritizes patient needs. Some cam-

*Corresponding Author: Reshma Gupta, MD; Email: Regupta@ucdavis.edu; Telephone: 916-734-2737; Twitter: @ReshmaGuptaMD; @DrSimpsonHSR; @dr_dmorgan.

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puses conducted analyses using both electronic health record data and input from patients and their care teams to identify clinical needs and determine patient outreach plans. Some approaches used machine learning models to identify patients at highest risk of hospitalization or emergency department visits over the next 12 months and to conduct additional outreach to schedule these patients in primary and specialty care if clinically appropriate. Similarly, surgical specialties identified the highest-priority nonemergent surgeries for scheduling, including cancer resection, radiation therapy, and pain-management procedures. Similar guidance toward the most meaningful care has been prioritized within the United States Department of Veterans Affairs.

The rapid deployment of telehealth and payment models that reimburse video and in-clinic visits equally created new opportunities for medical centers to expand high-value care in lower-cost home settings. Similarly, new infrastructure is being developed to help define smarter use of virtual visits and home-based lab collection and monitoring.

Medical centers also must pay careful attention to redeploying service capacity for underused, high-value services. The pandemic uncovered existing staff that could be redeployed to support these changes. For example, with an "all hands on deck" mentality during the pandemic, in some medical centers, analysts or care managers from less-prioritized or duplicative areas were reassigned to vital COVID-19 efforts. Medical centers may realize that this staff can provide more value in the future by supporting increased high-value, affordable healthcare.

DELIBERATELY AVOID LOW-VALUE CARE

During the intial wave of the pandemic, medical centers greatly reduced the care they provided, often focusing on delivering essential care. This preparation for a surge of COVID patients had the effect of halting many unnecessary services by moving care from the clinic to home under new reimbursement changes, such as those affecting telehealth payments. The experience of reducing low-value medical services and visits can be extended to limiting unnecessary diagnostic testing. Medical centers could, for example, focus only on tests that advance care plans; reduce unnecessary blood draws, procedures, and vital sign checks on stable patients; shift to medications with less-frequent dosing intervals; and consolidate visits by treatment teams.[10,11]

Medical centers, however, now face continued pressures to increase revenue because 75% report their organization's top priority is focused on increasing patient volume.[12] Nearly 95% of healthcare payments have been based on fee-for-service models,[13] and the COVID-19 pandemic highlighted the financial vulnerability of our health system when we reduce in-person care, especially among rural medical centers who often have no financial reserve.[14] Similarly, nearly half of hospitals' revenue comes from surgical admissions, though not all of these are necessary.[15-18] The fiscal realities facing medical centers make it challenging to not simply "ramp up" all service, regardless of necessity, in the context of payment models dependent on fee for service, which are present in most areas of the country.

PROACTIVELY AVOID WORSENING HEALTHCARE DISPARITIES

As medical centers reboot, operational and clinical leaders must proactively view changes through an equity lens to avoid exacerbating health disparities among vulnerable populations. The pandemic has focused national attention on the severity and pervasiveness of disparities and created an imperative for substantive action to evaluate how every decision will affect health equity. For example, medical centers are expanding use of telehealth to improve patient outreach. However, in a survey of primary care physicians, 72% said they have patients who are unable to access telehealth because they do not have access to technology.[3] Exclusion of these patients from programs risks worsening health disparities. In a recent survey, nearly 65% of medical centers report reexamining existing policies, protocols, and practices for patients at risk of disparities.[12] Medical centers now have an opportunity to strengthen, not eliminate, existing services such as education and community outreach programs that support vulnerable patients to improve trust among patients and improved downstream health outcomes even with recent financial losses in mind.

REFORM TO SUPPORT HIGH-VALUE CARE DELIVERY

Medical centers nationwide will need payment reform that provides greater financial stability beyond the pandemic to support high-value care delivery. They also will need flexibility to invest in prevention and to deliver the appropriate intensity of care to meet patients' and communities' needs.[15-17] Options to provide this support include prospective population-based payments that may create more resilience in protecting access to care when it is most needed. Models can include fully capitated payment for physician practices.[19,20] For example, after Vermont entered a single accountable care organization (ACO) model with the Centers for Medicare & Medicaid Services (CMS) in 2018, they not only generated a $97 million Medicaid savings, but also had a financial cushion that was later used in their COVID-19 response.[21,22] The advanced payments allowed primary care practices and community agencies to invest in a digital tool to support outreach to patient at high risk for virus complications.

Hospitals similarly can adapt global budgets that incentivize financial stewardship by encouraging clinicians to resume necessary services and not unnecessary ones.[16] For example, CMS partnered with Pennsylvania's Department of Health to provide prospective all-payer global budgets for rural hospitals and Maryland's Health Services Cost Review Commission that negotiates a budget with each hospital. During the COVID-19 pandemic, hospitals in these programs have had more financial protection from fluctuating finances by allowing for easier shifts in service delivery location and adjustments in rates to compensate for declines in visits and procedures.[23]

Policy makers and payers also can hold medical centers accountable to evidence-based guidelines and appropriate use of care, especially when necessary but expensive (eg, percuta-

neous coronary interventions, spinal surgeries, or cancer care). Funding agencies, additionally, can support these efforts by focusing on research, dissemination, and reliable implementation of these practices.

CONCLUSION

The COVID-19 crisis presents a tremendous opportunity for each medical center to revitalize healthcare. This opportunity can be seized only with reform by policy makers, payers, and regulatory agencies who encourage restarting high-value care without low-value services. We must take deliberate action so the nation's medical centers can better meet patients' needs to make healthcare more resilient, efficient, and fair.

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