

HEALTH SERVICES RESEARCH, MEDICARE, AND MEDICAID: A DEEP BOW AND A RECHARTERED AGENDA

By Donald M. Berwick

From their inception, Medicare and Medicaid have been shaped and guided by health services research (HSR) and its people. The linkages are numerous: ideas (like Diagnostic Related Groups, or DRGs, Resource-Based Relative Value Scale, or RBRVS, and Accountable Care Organizations, or ACOs), tools (like those from the RAND Health Insurance Experiment, the Medical Outcome Study, and the HCAHPS family), frameworks, and, of course, people who oscillated between academia and government, to the benefit of both.

As administrator of the Centers for Medicare and Medicaid Services (CMS) from 2010 to 2011, I saw productive contributions of HSR to CMS policy, regulation, and operations every day. That is a track record to be proud of. But there are gaps, some big ones, and a rechartered agenda for HSR could help boost American health care to its next and needed levels of performance.

The following are 10 suggested topics for HSR to focus on in the next decade, more understanding of which would help health care leaders, including CMS, to move more rapidly toward better care for individuals, better health for populations, and lower per capita cost through improvement: the “Triple Aim.”^{1,2}

1. *Better ways to involve doctors in change.* Today it is difficult to find a health care executive, clinical leader, or policymaker who does not hunger to know how better to engage physicians in the pursuit of quality improvement and lower costs. The overwhelming majority of tactics (far too many, in my view) involve changing payment, carrots and sticks, mostly. The harvest has been complexity, demoralization, and misdirected clinical energy. We need a deep breath and a reboot, and HSR ought to open wholly new thinking about how training, support, organizational design, information technology, and leadership practices—as well as payment—could help doctors help systems more.
2. *Transitional business models for hospitals.* Fee-for-service payment seems to be fading. Yet almost all hospitals remain tethered to business strategies that depend on the growth of revenue, market share, occupancy, and utilization. The common image is of a health care executive with “one foot on the dock and one foot on the boat,” torn between volume-driven payment and global payment in one form or another. HSR needs to supply realistic models for the transition of hospitals to new payment.
3. *Scaling changes.* The improvement movement and health care reform have facilitated the creation of many new care models, but the spread of effective changes to large scale remains far too slow. HSR should use the best of sociology, organizational sciences, engineering, and other disciplines to produce better methods of spreading and scaling up changes that work.
4. *Molding the beliefs and expectations of patients, families, and communities.* Blaming patients for unrealistic expectations and cost insensitive behaviors has become a sport, but one without a footing in good science. What, exactly, are the expectations of patients, families, and communities with respect to the excessive use of technology, the search for cures under conditions of futility, the value of evidence as a foundation for clinical decisions, the best locations for care of various conditions, the value of self-care, and more? And when those expectations fail to converge with the science, what are the ways to foster a more mature understanding? I think that the dominant tactics today under the rubric of “patient engagement”—shifting costs to patients so that they have “skin in the game” and will therefore make wiser choices—are nearly bankrupt scientifically, administratively wasteful, economically regressive, clinically risky, and, often, cruel. HSR should be providing better and wiser options.

5. *Understanding the nature and magnitude of waste in health care.* The immense HSR literature on variation in practice and resource use, whether national or international, suggests strongly that waste is pervasive in health care. The end result is clear: Costs vary greatly without correlation with quality or outcomes. But overall, and incredibly, we still do not know why. “Where is the waste?” is a question begging for more engagement by the HSR community.
6. *Creating the new workforce.* It stands to reason that new care designs, which we need, may require, or at least invite, new clinical roles that break the boundaries and assumptions of the guilds whose roots lie in past centuries. It’s a hot potato, since professions defend their prerogatives fiercely. Nonetheless, HSR should be helping, with data and evidence, to envision and construct the health care workforce of the future.
7. *Exploiting and developing telehealth.* “Move knowledge, not people,” is a call to arms for new designs for healing and health. Innovations in telemedicine and telehealth are abundant and very promising. It will take the best of HSR to sort the value from the glitz and to extend the scientific foundations of non-visit care. This is ideal terrain for multidisciplinary research, embracing sociology, cognitive psychology, engineering, and many other disciplines.
8. *Rationalizing measurement.* Measurement in health care has gone wild. HSR has contributed sound approaches to assessing care, with deep roots in the RAND Health Insurance Experiment and many other pioneering efforts. But, overall, the enterprise of performance measurement has become a relative free-for-all, with numerous agencies and stakeholders exercising their prerogatives to demand metrics in the form they want them, when they want them, and from whom they want them. Reconciliation, harmonization, parsimony, and utility are often discussed, but progress has been slow, and the resulting burden on those who give health care has become not just onerous but, frankly, silly. The costs of measurement have become huge. It is time to make certain that the costs and benefits of metrics are understood, that elegance and a sense of proportion enter the measurement enterprise, and that we come to know which measurements add value in their form and use and which do not. That is a task for HSR.
9. *Redesigning the “scoring rules” used by key federal actors.* The scoring rules used by the Office of Management and Budget, the Congressional Budget Office, and the CMS Actuary are profoundly important to determining which policies see the light of day and which do not. But current scoring rules, which can be traced to HSR, rest on a canon of beliefs and habits regarding statistical certainty and forms of evidence that simply has not kept up with modern thinking about epistemology, learning-in-action, and pragmatic research. As a result, scoring rules tend to constrict investments in the growth and development of knowledge, chill responsible and needed risk taking, and place the status quo in far too privileged a position. We need better methods.
10. *Developing more dynamic evaluation methods.* Similarly, the usual approaches of HSR to the evaluation of programs and projects are far too slow, costly, and cumbersome to support health care reform that moves quickly enough. CMS badly needs new, agile, lean, pragmatic, and dynamic program evaluation methods.

Overall, HSR can take a deep bow for its assistance to the world of Medicare and Medicaid policy, regulation, and operation. But to be even more helpful, its future agenda should invest in the yet unmet needs for knowledge. Especially at a time of such conflict and confusion in health care policy, HSR has both the burden and the privilege to lead on new paths to better care, better health, and lower costs.

References

1. Berwick DW, Nolan TW, Whittington JW. The Triple Aim: care, health, and cost. *Health Aff.* 2008;27(3):759-769.
2. Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: the first 7 years. *Milbank Q.* 2015;93(2):263-300.

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