What Does #MeToo Have to Do With Value-Based Health Care?

written by Theresa Hush | February 1, 2018

Are we measuring the right things in Value-Based Health Care? That's the question I am asking myself while reviewing recent efforts by CMS to create better measures of health care value, called Meaningful Measures. Given current, widespread reports of sexual abuse and my recent reading about the dismal state of elder health care, I can't respond affirmatively.

A Value-Based Health Care System should curtail rising health care costs and promote better health for individuals. But we can't miss the forest for the trees. If we focus on the minutia of medical processes or even outcomes of moderate value, yet miss crucial quality-of-life issues, can we claim that our system is value-based? No, we just get one that is a little less expensive.

That failure to deal with serious issues that impact health and wellbeing happens not across the board, but group by group. It happens because we decide that this or that issue is not sufficiently broad to matter when we are deciding about what counts in quality of care. It also happens because we often see health care from the provider perspective, especially since providers as a group are largely defining the quality measures.

This is how we marginalize the interests of women, of people of color and of people who have health care issues beyond their control. We decide through our various systems, health care as well as political, that their voices are not relevant. And this is how we end up with a maternal mortality rate that is the highest in the industrialized world. To find a better path, we need to take a closer look at how we failed girls trying to excel at a sport. And how we end with adults losing choices in later life.

Health System Failed Girl Gymnasts

Reports of sexual abuse of girl gymnasts on the USA Gymnastics team percolated for decades, but were not taken seriously until a critical mass of young women stepped forward to raise their voices collectively. The significant issue here is not simply that a trusted physician was the perpetrator; many others in equally trusted positions have preyed on children, both girls and boys. Here, however, there were many serious lapses in the treatment milieu that enabled the physician to sexually abuse the girls:

- Medical treatment was questionable, at best, and should clearly have been reviewed for evidence;
- The gymnasts were required to submit to exams and treatments without any recourse to refuse or complain;
- Treatment was provided in some cases at the physician’s private home, not in a health facility with the aid of a nurse or another adult. Even with parents present, he hid his actions from view;
- Internal “treatments” were conducted without gloves;
- No one followed up on suspected issues brought by patients.

It is a tragedy that the girls’ parents were convinced by the authority of the gymnastics system and the physician’s reputation, or were persuaded by presumed medical expertise, to override their daughters’ concerns and miss the abuse. But that is also evidence of how important it is—especially in systems rooted in trust—to seek and include patient feedback.

What if those girls were given permission to respond, even in the most basic way, to their medical care as members of the gymnastics team? How different would the outcome have been? Would they have raised concerns about their exams or the conditions in which they occurred? Would they have evaluated their “adjustments” as having functionally relieved their symptoms? Would it have made a difference?

We will never know for certain how the abuse might have been discovered earlier, curtailed or even avoided altogether by a system that respected the rights and feedback of the girls. But we do know that in health care—as in the workplace, in schools and in churches—the powerful are protected by silencing or minimizing the voices of the less powerful. If we truly want the patient to be at the center of health care, it is essential that we actively solicit patient input about quality of care.

Older Adults Lose Choices In Health Care, Along with Life

As the sentencing in the gymnast abuse case concluded last week, I finished rereading *Being Mortal* by Atul Gawande, MD. Its stark portrayal of end-of-life care in a medical system on autopilot is directly relevant to the question of ensuring value and avoiding excessive cost.

Dr. Gawande rightly points out all the reasons why providers are geared to do more, try more, even when there is little chance to reverse rampant disease or body failure. Advance Directives by patients, which feature in current Medicare quality measures as well as future Meaningful Measures, respond to this concern by, at least, stimulating the conversation about end of life.

Even if completed, however, Advance Directives may be written and signed before a crisis becomes real, only to be later rethought by the patient, family or physician at the moment of care. But clarifying intent for further treatment must be part of an ongoing conversation related to patient life desires, revisited as circumstances change. The push to create the continual conversation—much like medication reconciliation—is being missed by the entire community involved in measure development.

This excellent book on dealing with decline and aging is also relevant to how our health care system affects quality of life. For a range of reasons, many older adults' need for stronger support systems has outpaced their ability to remain independent, and many of those adults cannot stay with their families. They reside, instead, in assisted living and nursing homes, most of which have strict regimens that proscribe their activities and choices. These facilities are required to participate in quality reporting for Medicare, which reimburses them for post-acute care only (custodial care is often covered by Medicaid or private pay).

Nursing home quality reporting addresses falls, infections and bedsores. It also includes measures to control costs, such as readmissions and cost per beneficiary. Nursing home and physician quality measures do not, however, reward patient choices, privacy, integrity and independence. While CMS Meaningful Measures include a placeholder category for patient-directed choices and input, there are—as yet—no measures assigned to this module.

Like the gymnast girls, older adults often lose their voices in managing their health care as well as in choosing their living circumstances. They are directed, expected to comply with orders they may not accept, and mostly do not select their providers. The system of quality measurement may help protect them from physical harm, but—with the remarkable exception of new groups of very innovative providers and administrators trying to change the industry—the system does little to encourage higher functionality, more patient choice or more independence.

While change from industry leaders is positive, the CMS Meaningful Measures that reflect this area of health care aren't inspiring. The point of the measurement system is to guide the standard of care for *everyone*. Without an adopted standard of care and measures that determine how each part of the system—each facility and provider participating in Medicare, and each process and health outcome that comprise the definition of value—stacks up against that standard, there are consequences for the value of the system as a whole. Better patient options may be available because of compassionate leaders in the industry as well as family and patient desires. But the risk is that only to those who can afford the higher cost can choose those options. Where leadership and funds are average, the lack of a higher standard of care promotes the status quo and provides no blueprint for improvement.

There should be systematic adoption of measures that incorporate incentives for mainstream elders to make medical and reasonable life decisions. These include, among other preferences, self-determination of private time versus group activities, scope of involvement in group activities, diet preferences, ambulation as desired or capable, and participation in decisions about their treatments and care.

#MeToo Is Partly A Story of Deficient Health Care

I am energized by the army of women who have come forward and testified to our collective history of harassment and abuse. Sexual harassment comes in many forms and affects victims profoundly, whether or not they feel able to speak.

Abuse and sexual violence, however, should be protected health care territory for victims. They should be helped to acknowledge the abuse, not hindered, and supported in recovery. But there is not a single quality measure for screening of sexual abuse. The existence of sexual abuse as a "condition" is not even acknowledged, nor its harmful impact on the patient.

In CMS Meaningful Measures, there is an emphasis on measures that have significance in terms of outcomes, some of which have questionable data. There are measures related to smoking, blood pressure and hemoglobin A1C. Smoking, hypertension and diabetes have an unquestionable effect on mortality, health care costs and quality of life. But so does sexual abuse.

It is impossible to include every condition, every circumstance in a discrete set of quality measures that are intended to define what our health care system should look like. But should we not account, in some way, for patients who experience emotional trauma. Whether it is sexual abuse, rape, elder or child abuse, or another form of emotional trauma—shouldn’t our health care system center as much on patients as on costs?

Ultimately, troubled people cost money and lives.

“Meaningful” Must Be Measurable and Patient-Oriented

The CMS Meaningful Measures effort is still in its infancy. But early signs indicate a preference for provider simplicity and cost containment without accounting for the other side of the equation: patients.

The drive to include consumers in their health care system should be more than a “patient engagement” scheme. It should start with measuring and sharing what is important to patients, and including them in both the process of measure development and the review of data. Performance measures, to be truly meaningful, should not be the exclusive terrain of providers. They were driven by a Value-Based Health Care system based on payments coming primarily from insurance and governmental payers. But now it is patients who are paying for much of their health care through premiums, copays, deductibles and uncovered charges. Those patients deserve to participate in the final round of Value-Based Health Care.

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