Transforming Health Care to Address Value and Equity: National Vital Signs to Guide Vital Reforms

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The US health care system is failing to deliver value and equity. Life expectancy has been declining nationally. Health care costs in the United States are the highest in the world. Medicare alternative payment models have yielded modest reductions in costs but have generally not improved health or equity. Fundamental change is needed beyond redesign of alternative payment models. Health care must embrace equitable improvement in the national Vital Signs initiative, invest in primary care, and collaborate with communities.

National Vital Signs
National Vital Signs are core metrics produced by the Institute of Medicine (now, the National Academy of Medicine) for tracking improvements in health, health care costs, engagement of the public in its health, and health care and quality. Examples include the percent of adults who are overweight and obese; use of addictive substances including tobacco, alcohol, and illicit drugs; individual engagement in health-related behavior; effective clinical care; and individual well-being.

National Vital Signs are metrics that matter. Many are behavioral, social, or physiological metrics that powerfully influence health, health care costs, and health disparities. Thus, these metrics are well-suited to guide and motivate health care toward value and equity.

Unity in Purpose and Policy
The US Department of Health and Human Services (DHHS) should lead by establishing equitable improvement in national Vital Signs as a top national goal. DHHS could begin by convening an interagency task force that includes community membership to align social, public health, and health care policies and regulations with this goal. Notably, the Centers for Medicare & Medicaid Services (CMS) should align its policies and payments with this goal and actively promote similar alignment of policies and payments by all health care payers and players.

Transformation of Health Care Through National Vital Signs
National Vital Signs, when tied to payment, could transform health care. This could alter the health system model from its primary focus on treating illness to a complementary focus on equitable improvement in health and wellness. Pay for performance has had limited success, partly because it rewards improvement in processes that are only remotely related to health care value and equity. A systematic review found that pay for performance was associated with improvements in some ambulatory care processes, but was not consistently associated with improved health outcomes. Linking payment to equitable improvement in national Vital Signs could mitigate the limitations of pay-for-performance models. For example, payment redesign aligned with equitable outcomes could encourage health care organizations to implement care models that involve partnerships between prepared health care teams, activated patients, and community organizations.

One well-known model that embodies these approaches is the chronic care model, which was developed 25 years ago. The chronic care model is backed by extensive research and was the foundation for the patient-centered medical home. Its core elements (ie, redesign of health care delivery, including team-based care; patient self-management support; clinician decision support; effective and efficient health information systems; and community partnerships) are essential to equitable improvement in national Vital Signs and to rebuilding primary care.

In addition, incentivizing equitable improvement in national Vital Signs could transform how health care organizations partner with communities to address social determinants of health. Current CMS alternative payment models are narrowly focused on short-term cost savings and are often insufficient for promoting meaningful community partnerships. National Vital Signs, if adequately incentivized, could foster mutually beneficial community partnerships and investment by health care systems in underserved surrounding communities and in establishment of lasting community partnerships to address social determinants of health. These incentives could transform hospital community-benefit programs from onerous Internal Revenue Service requirements to core hospital missions. For instance, Bon Secours Hospital supported affordable housing in the low-income, minority community of West Baltimore. Other health care organizations deploy community health workers who bridge health care and community by linking patients with community resources to address patients' social determinants of health.

Streamline Health Care Outcome Measures
Clinicians struggle with reporting performance for multiple measures. Prioritizing national Vital Signs across payers could reduce this burden. Selection of specific metrics could be based on the level of measurement (practice, health care system, or health plan); the effect of the metric on population health, spending, and health equity; the modifiability of the metric; the potential of the metric for fostering partnerships between health care, public health, and communities; and the potential of the metric for transforming health care delivery.

Value-Based Primary Care Payment Reforms
A robust and thriving primary care system is the bedrock for promoting value and equity. Incentivizing equitable
improvement in national Vital Signs could facilitate the implementation of high-quality primary care and should include several considerations. First, new incentive strategies must support primary care through adequate per-member per-month payments, adjusted for age, sex, medical morbidity, and social risk (eg, using social deprivation indices). Accounting for social risk in payment better aligns resources with patient needs. Payments to primary care practices must be sufficient to support and sustain chronic care models that support equitable improvement in national Vital Signs. This also means ensuring access to high-quality primary care in both urban and rural underserved communities through sufficient adjustments to payments to practices (including community health centers) that serve these communities.

Second, incentive payments could initially address progress toward equitable improvement in national Vital Signs. Addressing national Vital Signs is inherently more complex and challenging than addressing process measures. Pay-for-performance models run the risk of penalizing safety net practices that serve patients at higher social risk who confront more barriers to improving national Vital Signs. Rewarding incremental progress acknowledges this challenge and mitigates potential financial penalties for safety-net practices and health care systems. Depending on the metric, the measurement might be done at the practice, health care system, or accountable care organization level. Blood pressure control, a current clinical performance measure, could be heavily incentivized at the practice level while improvement in healthy body weight or smoking cessation, metrics potentially requiring even greater systems-community engagement, might be incentivized at the hospital system or accountable care organization level.

Third, pay for performance should not undermine the core elements of primary care. National Vital Signs, when coupled with reforms in payment and delivery models, revitalize primary care by focusing on high-level, clinically meaningful goals. Unintended consequences could be monitored through assessment and public reporting of core primary care elements by practices.

A Vital Future
Full-scale adoption of national Vital Signs by health care could revitalize primary care and transform US health care. This approach offers a path out of the quagmire of overmeasurement of health care processes by prioritizing meaningful and compelling goals for health care teams. Adoption of national Vital Signs means reducing the plethora of constraining process measures and replacing many of them with fewer, high-level, clinically meaningful measures.

Success could be transformative for physicians and other health care professionals by trusting them in acquiring self-management skills and by addressing their social determinants of health. This new context could help reduce occupationally related stress and dissatisfaction among health care professionals by improving team autonomy, promoting respect for team competence, and fostering meaningful relationships within teams, between teams and community partners, and ultimately with patients and families. These changes could revitalize primary care and potentially the broader health care system by instilling new meaning and purpose in health care.

These changes will not be easy. Transformative change is inherently challenging, typically invokes fierce resistance, and is often considered impractical and idealistic. Success will require bold action by DHHS. It requires long-term investment by the CMS and other payers in primary care that is comparable to the percentage of health care spending that is invested by other high-income countries. Success requires accountability through major payment reform. Success requires patience. It took Kaiser Permanente 13 years to improve its blood pressure control from 44% to 90% among its members. Success requires DHHS to promote the adoption of these reforms by all payers, not just Medicare. It will require leadership from DHHS in supporting the integration of Vital Signs into electronic health records and health information exchanges to facilitate effective use of data to measure and inform national Vital Signs progress. Success also will require adaptation of strategies, measures, and payment models along the way to ensure progress toward improvements in equity in national Vital Signs while minimizing unintended consequences.

Adoption of national Vital Signs by health care makes sense. Just as health care professionals prioritize patients’ vital signs during a health crisis, DHHS and CMS must prioritize national Vital Signs to address the national health care crisis in value and equity.

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