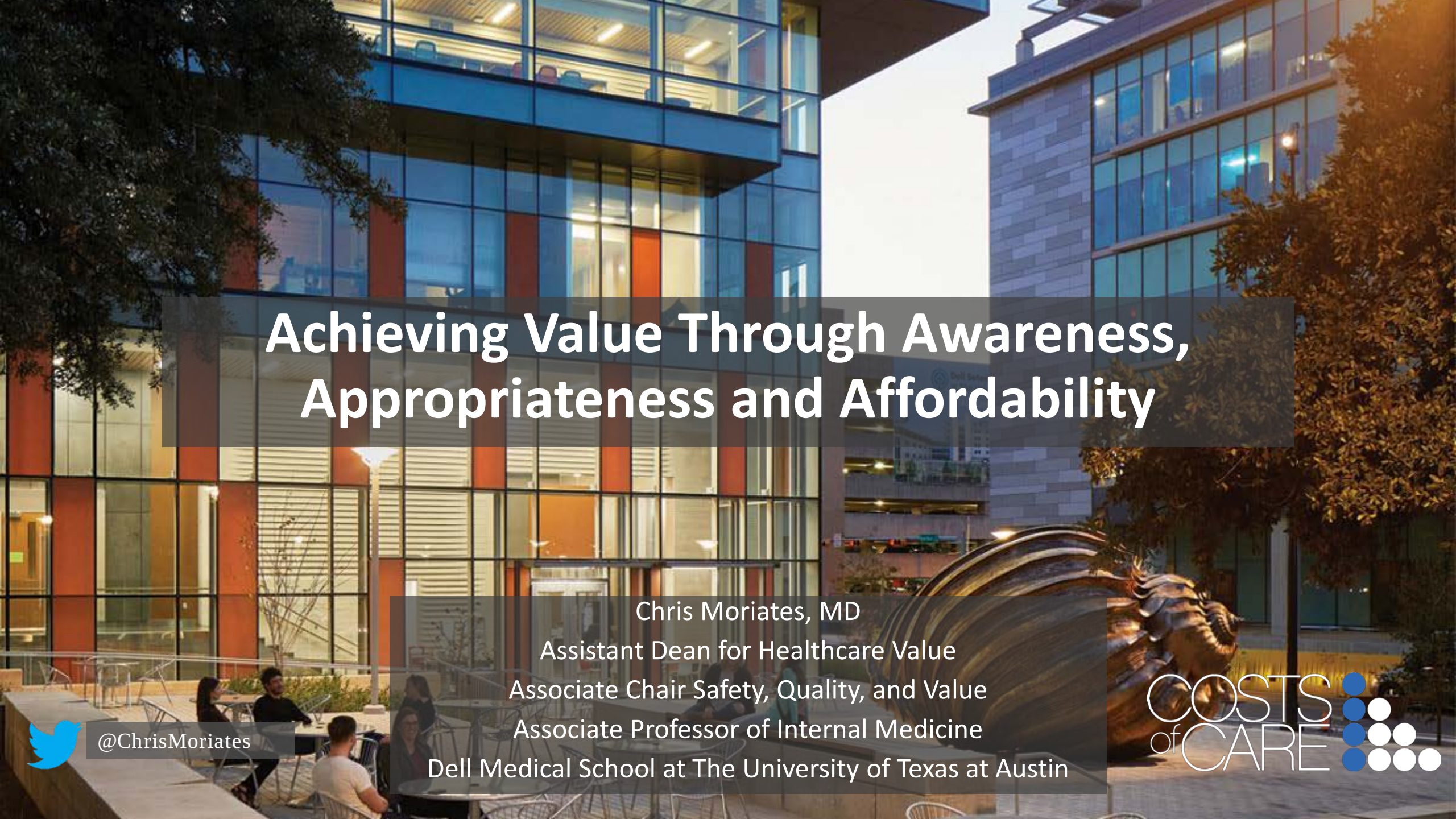


Achieving Value Through Awareness, Appropriateness and Affordability

Chris Moriates, MD

Assistant Dean for Healthcare Value

Associate Chair Safety, Quality, and Value

Associate Professor of Internal Medicine

Dell Medical School at The University of Texas at Austin

@ChrisMoriates

COSTS of CARE

Christopher Moriates, MD

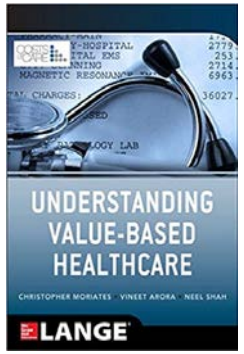
Executive Director, Costs of Care

Assistant Dean for Healthcare Value and

Associate Chair for Quality, Safety & Value

Dell Medical School at the University of Texas

Disclosures



Royalties from McGraw-Hill for “Understanding Value-Based Healthcare”

Grant support from

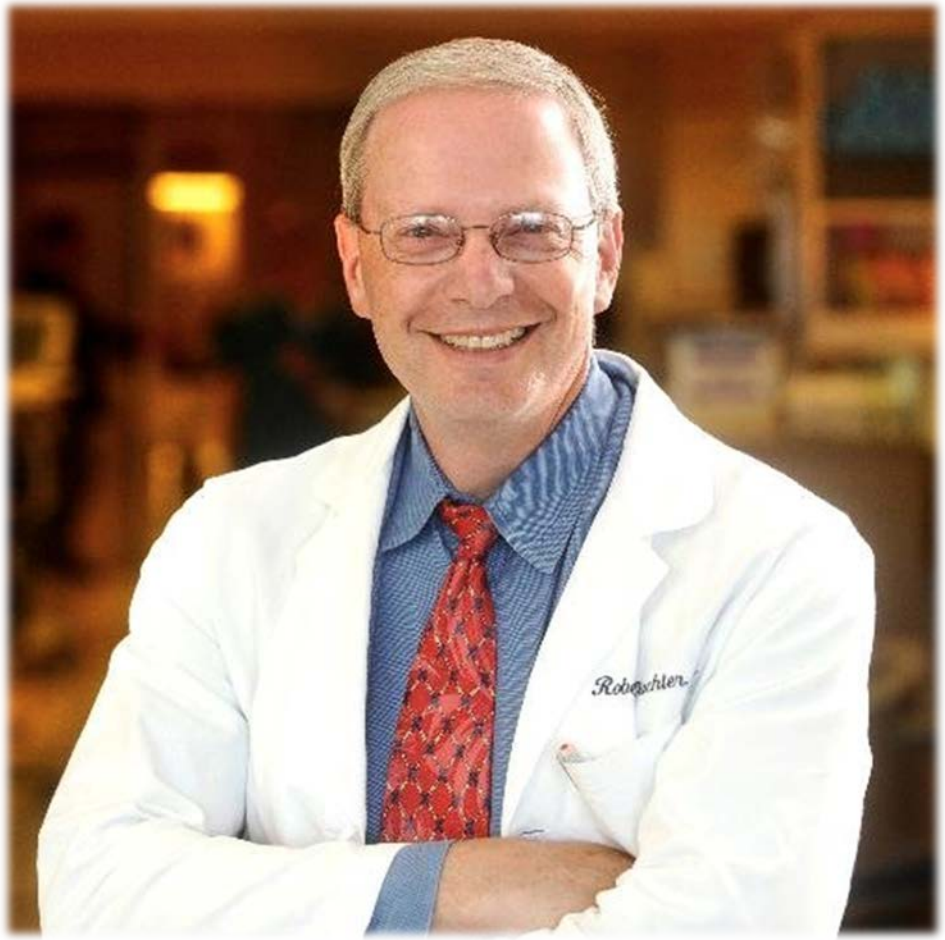
ABIM Foundation, Macy Foundation, Episcopal Health Foundation, and ACGME

Executive Director,

Costs of Care (non-profit)

“You folks need to be prepared for a career that will be massively different from mine.

You will be under relentless pressure to deliver the highest quality, safest, most satisfying care … at the lowest possible cost.”



“What exactly were *you* trying to do?”

¯_(ツ)_/¯

POLITICS APRIL 1, 2019

Healthcare Once Again Tops List of Americans' Worries

BY **JIM NORMAN**

Healthcare, Budget Deficit Top List of Americans' Worries

Now I'm going to read a list of problems facing the country. For each one, please tell me if you personally worry about this problem a great deal, a fair amount, only a little or not at all.

	Great deal	Fair amount	Only a little/Not at all
	%	%	%
The availability and affordability of healthcare	55	25	21
Federal spending and the budget deficit	50	30	20
Hunger and homelessness	49	30	20
Drug use	47	26	27
Crime and violence	47	28	25

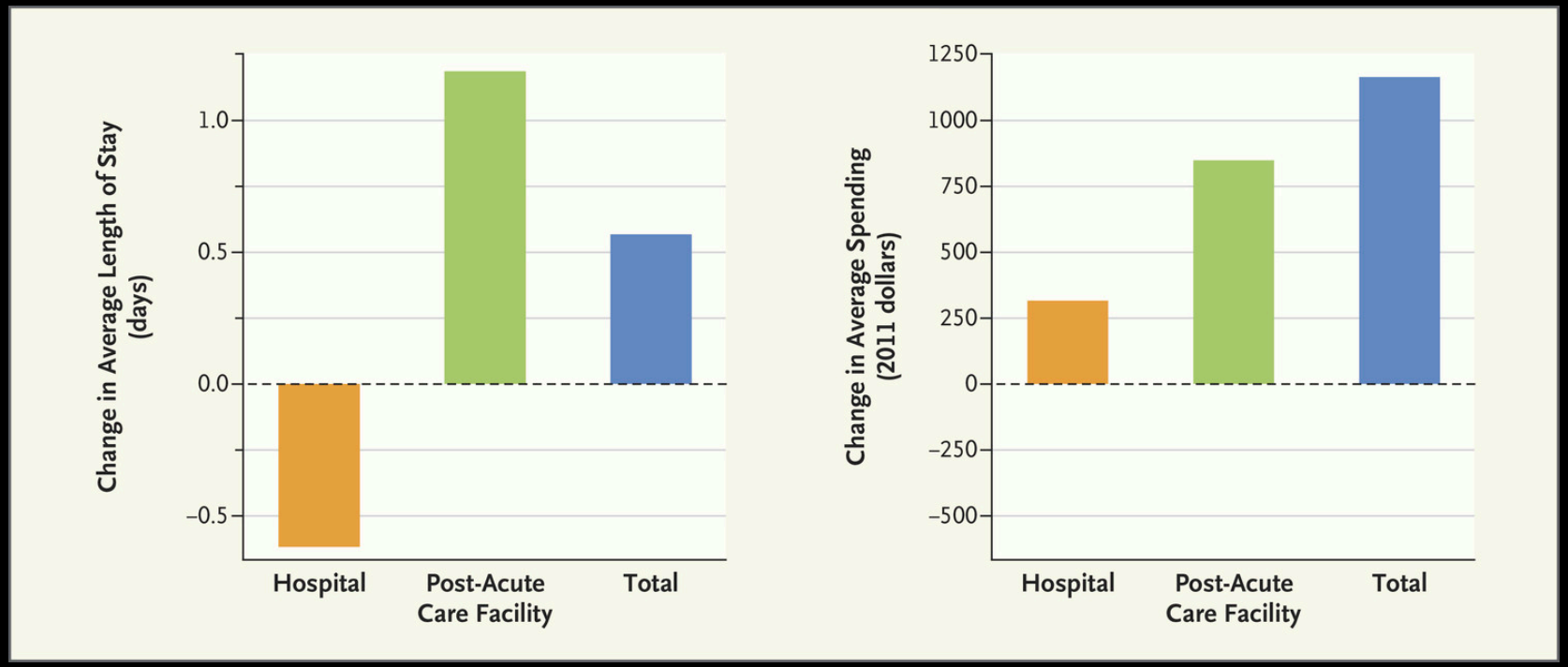

We can do better

The University of Texas at Austin
Dell Medical School

$$\text{Value} = \frac{\text{Outcomes that matter to patients}}{\text{Total Costs of Care}}$$

Measuring What Matters

Changes in Average Length of Stay and Spending among Medicare Beneficiaries, by Setting, 2004–2011.



Barnett ML et al. N Engl J Med 2017;377:4-6.

The NEW ENGLAND JOURNAL of MEDICINE

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PERSPECTIVE

MEASURING WHAT MATTERS TO PATIENTS AND PAYERS

Home-to-Home Time — Measuring What Matters to Patients and Payers

Michael L. Barnett, M.D., David C. Grabowski, Ph.D., and Ateev Mehrotra, M.D., M.P.H.

Barnett ML, Grabowski DC, Mehrotra A. *New England Journal of Medicine*. 2017;377(1):4-6.

The University of Texas at Austin
Dell Medical School

$$\text{Value} = \frac{\text{Outcomes that matter to patients}}{\text{Total Costs of Care}}$$

Understanding Costs in Health Care

Costs have traditionally been hidden from clinicians and the public…

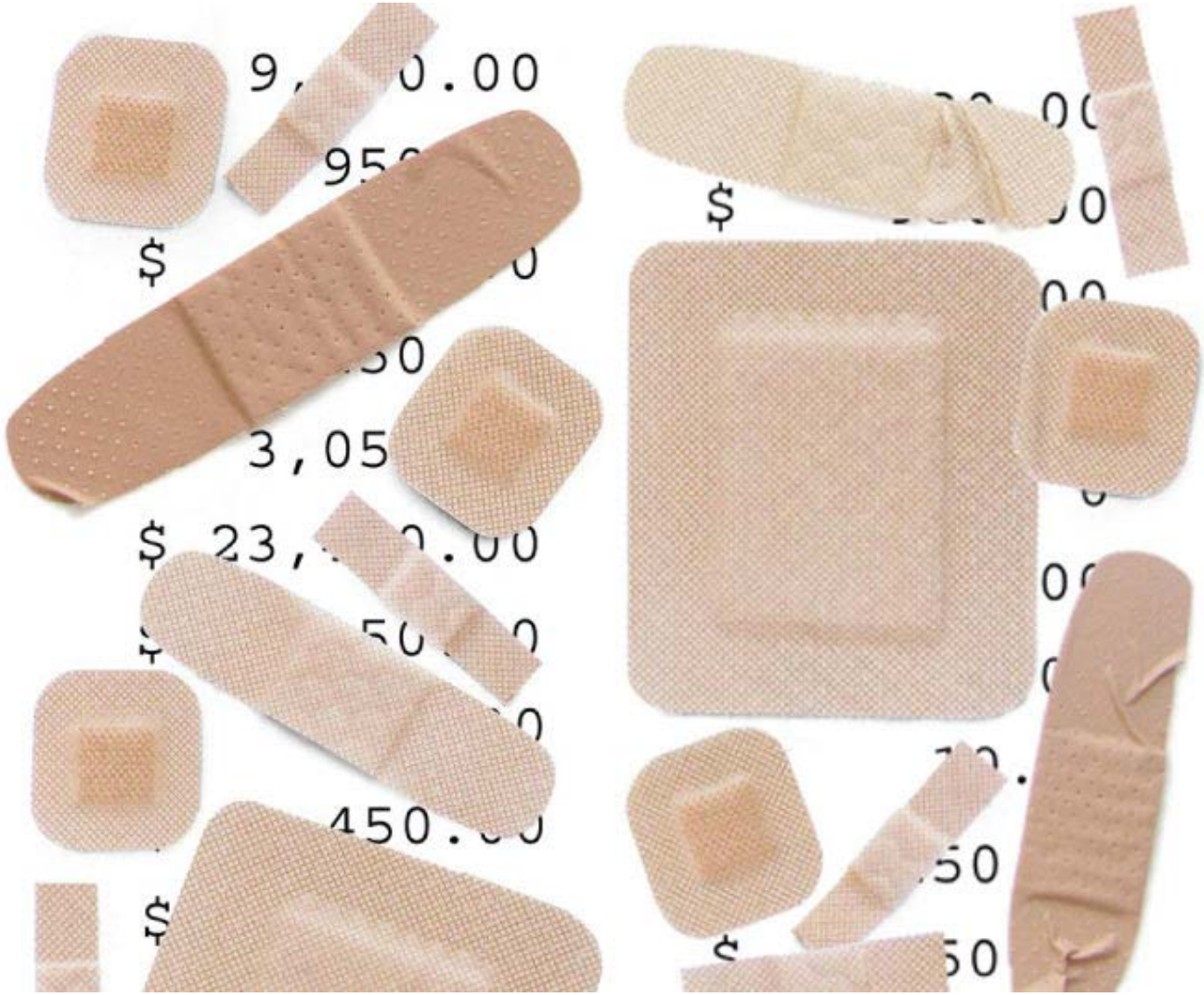

Image from: Wired Magazine, 2012

The New York Times

HEALTH

What Are a Hospital's Costs? Utah System Is Trying to Learn

By GINA KOLATA SEPT. 7, 2015

Dr. Vivian Lee set in motion a process that the University of Utah Health Care is using to save money and to improve care. Sallie Dean Shatz for The New York Times

RELATED

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Health Care Value

COSTS of CARE

Awareness

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An initiative of the ABIM Foundation

Special Article

Feb 25, 2013

The Value in the Evidence
Teaching Residents to "Choose Wisely"

Christopher Moriates, MD; Krishan Soni, MD, MBA; Andrew Lai, MD, MPH; et al

» Author Affiliations

JAMA Intern Med. 2013;173(4):308-310. doi:10.1001/jamainternmed.2013.2286

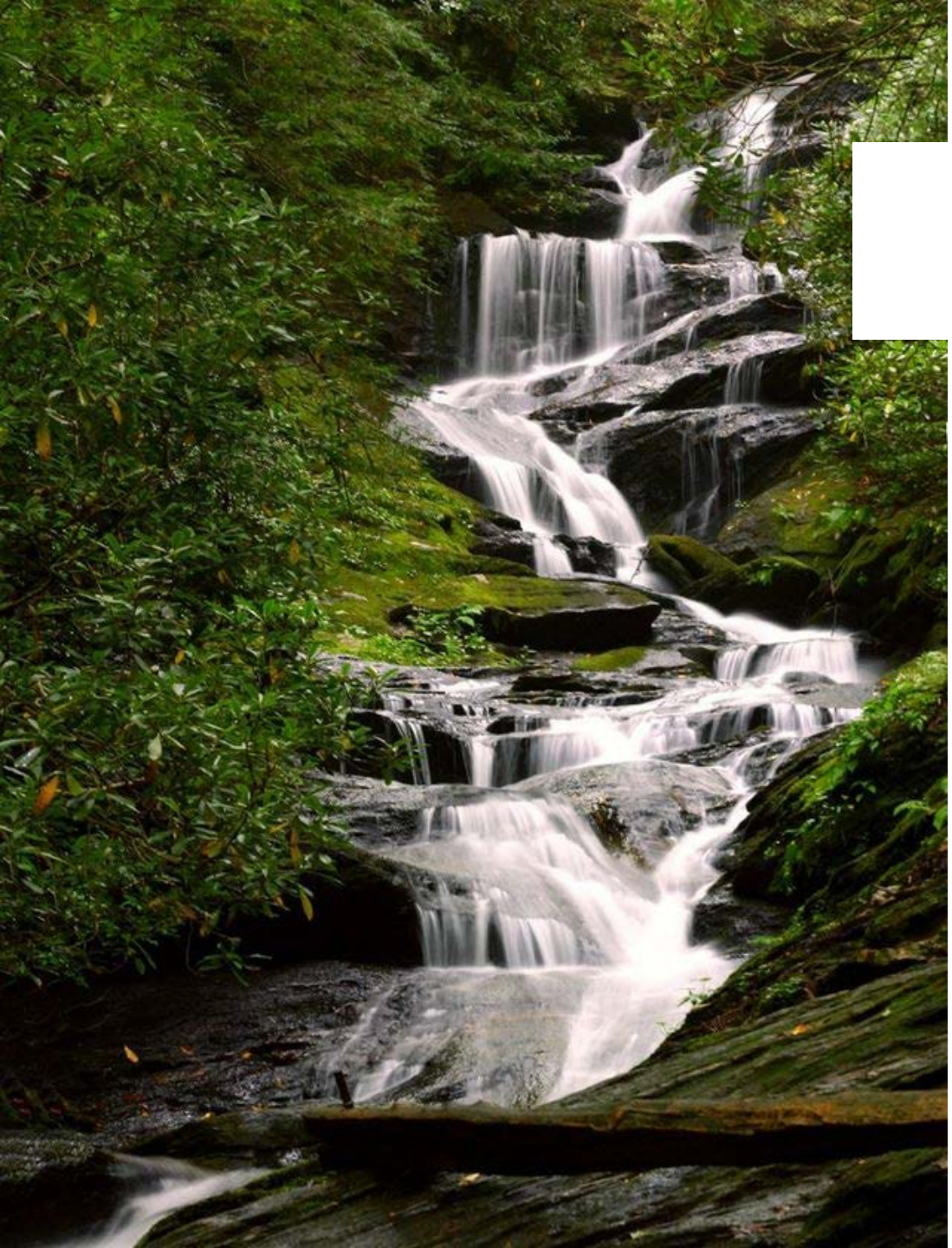
Cutting Out Waste

Table 2. Cost Estimates by Waste Domain

Domain	Costs, $US Billion	
	Annual Estimates	Total Range
Failure of Care Delivery		
Hospital-acquired conditions and adverse events[18-22]	5.7-46.6	**102.4-165.7**
Clinician-related inefficiency (variability in care, inefficient use of high-cost physicians)[27,28]	8.0	
Lack of adoption of preventive care practices (obesity, vaccines, diabetes, hypertension)[23-26]	88.6-111.1	
Failure of Care Coordination		
Unnecessary admissions and avoidable complications[19,29]	5.9-56.3	**27.2-78.2**
Readmissions[30,31]	21.25-21.93	
Overtreatment or Low-Value Care		
Low-value medication use[12,32-35]	14.4-29.1	**75.7-101.2**
Low-value screening, testing, or procedures[14,36,37]	17.2-27.9	
Overuse of end-of-life care[38]	44.1	
Pricing Failure		
Medication pricing failure[8]	169.7	**230.7-240.5**
Payer-based health services pricing failure[39,40]	31.4-41.2	
Laboratory and ambulatory pricing[41]	29.7	
Fraud and Abuse		
Fraud and abuse in Medicare[42-44]	58.5-83.9	**58.5-83.9**
Administrative Complexity		
Billing and coding waste[45]	248	**265.6**
Physician time spent reporting on quality measures[10]	17.6	
Total		**760-935**

From: **Waste in the US Health Care System: Estimated Costs and Potential for Savings.** JAMA. 2019;322(15):1501-1509.

An initiative of the ABIM Foundation



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE FREE PREVIEW

Incidental Findings on Brain MRI in the General Population

Meike W. Vernooij, M.D., M. Arfan Ikram, M.D., Hervé L. Tanghe, M.D., Arnaud J.P.E. Vincent, M.D., Albert Hofman, M.D., Gabriel P. Krestin, M.D., Wiro J. Niessen, Ph.D., Monique M.B. Breteler, M.D., and Aad van der Lugt, M.D.

RESULTS Asymptomatic brain infarcts were present in 145 persons (7.2%). Among findings other than infarcts, cerebral aneurysms (1.8%) and benign primary tumors (1.6%), mainly meningiomas, were the most frequent. The prevalence of asymptomatic brain infarcts and meningiomas increased with age, as did the volume of white-matter lesions, whereas aneurysms showed no age-related increase in prevalence.

UCSF Division of Hospital Medicine
High Value Care Committee

Committee described in: Moriates, et al. J of Hosp Med, 2014

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Official Blog of SHM

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3 Tips for Bringing Doctors and Data Specialists Together

By Chris Moriates | January 18, 2017 | 0

By:
Victoria Valencia, MPH, Assistant Director of Healthcare Value
Christopher Moriates, MD, Assistant Dean of Healthcare Value
Dell Medical School at The University of Texas at Austin

With tele-machines beeping, robots rolling by and so many different people rotating in and out of rooms, the hospital environment can be chaotic. Similarly, the data environment of many of our electronic health records (EHRs) can be quite unruly. EHR

MODULE 1 | Section 7

Care Redesign Case: Value-Driven Outcomes at University of Utah

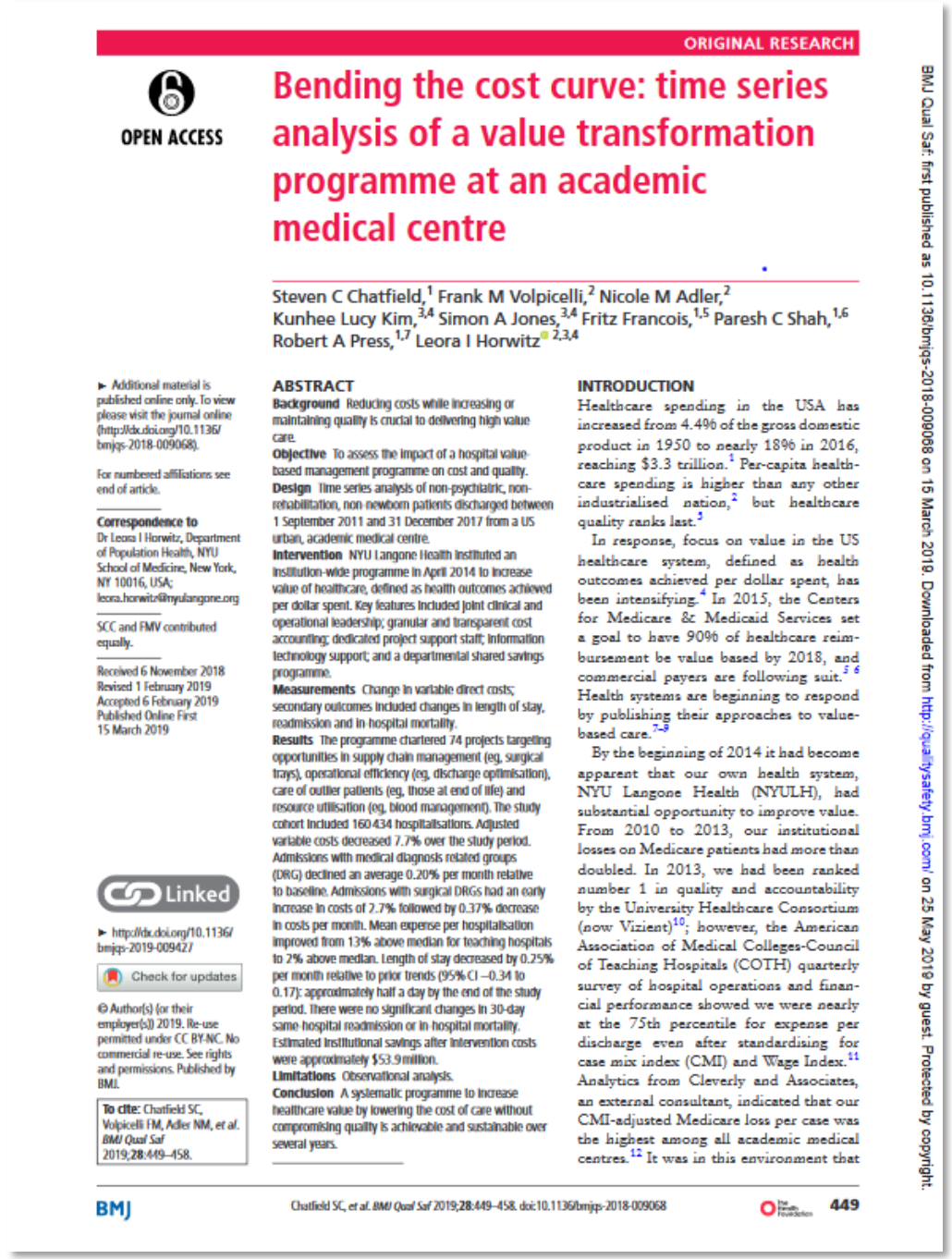
JAMA | Original Investigation | INNOVATIONS IN HEALTH CARE DELIVERY

Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes and Association With Reduced Cost and Improved Quality

Vivian S. Lee, MD, PhD, MBA; Kensaku Kawamoto, MD, PhD, MHS; Rachel Hess, MD, MS; Charlton Park, MBA, MHSM; Jeffrey Young, MS; Cheri Hunter, BS; Steven Johnson, LSMBB, MBA; Sandi Gulbransen, BSIE; Christopher E. Pelt, MD; Devin J. Horton, MD; Kencee K. Graves, MD; Tom H. Greene, PhD; Yoshimi Anzai, MD, MPH; Robert C. Pendleton, MD

Findings

In pre-post comparisons, implementation of the analytic tool was associated with a significant decrease in costs (7%-11% for total joint replacement and 11% for laboratory testing) and improvement in quality.



ORIGINAL RESEARCH

OPEN ACCESS

Bending the cost curve: time series analysis of a value transformation programme at an academic medical centre

Steven C Chatfield,[1] Frank M Volpicelli,[2] Nicole M Adler,[2] Kunhee Lucy Kim,[3,4] Simon A Jones,[3,4] Fritz Francois,[1,5] Paresh C Shah,[1,6] Robert A Press,[1,7] Leora I Horwitz[2,3,4]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2018-009068).

For numbered affiliations see end of article.

Correspondence to
Dr Leora I Horwitz, Department of Population Health, NYU School of Medicine, New York, NY 10016, USA; leora.horwitz@nyulangone.org

SCC and FMV contributed equally.

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Check for updates

To cite: Chatfield SC, Volpicelli FM, Adler NM, *et al*. *BMJ Qual Saf* 2019;**28**:449–458.

ABSTRACT

Background Reducing costs while increasing or maintaining quality is crucial to delivering high value care.

Objective To assess the impact of a hospital value-based management programme on cost and quality.

Design Time series analysis of non-psychiatric, non-rehabilitation, non-newborn patients discharged between 1 September 2011 and 31 December 2017 from a US urban, academic medical centre.

Intervention NYU Langone Health instituted an institution-wide programme in April 2014 to increase value of healthcare, defined as health outcomes achieved per dollar spent. Key features included joint clinical and operational leadership; granular and transparent cost accounting; dedicated project support staff; information technology support; and a departmental shared savings programme.

Measurements Change in variable direct costs; secondary outcomes included changes in length of stay, readmission and in-hospital mortality.

Results The programme chartered 74 projects targeting opportunities in supply chain management (eg, surgical trays), operational efficiency (eg, discharge optimisation), care of outlier patients (eg, those at end of life) and resource utilisation (eg, blood management). The study cohort included 160 434 hospitalisations. Adjusted variable costs decreased 7.7% over the study period. Admissions with medical diagnosis related groups (DRG) declined an average 0.20% per month relative to baseline. Admissions with surgical DRGs had an early increase in costs of 2.7% followed by 0.37% decrease in costs per month. Mean expense per hospitalisation improved from 13% above median for teaching hospitals to 2% above median. Length of stay decreased by 0.25% per month relative to prior trends (95% CI −0.34 to 0.17); approximately half a day by the end of the study period. There were no significant changes in 30-day same hospital readmission or in-hospital mortality. Estimated institutional savings after intervention costs were approximately $53.9 million.

Limitations Observational analysis.

Conclusion A systematic programme to increase healthcare value by lowering the cost of care without compromising quality is achievable and sustainable over several years.

INTRODUCTION

Healthcare spending in the USA has increased from 4.4% of the gross domestic product in 1950 to nearly 18% in 2016, reaching $3.3 trillion.[1] Per-capita healthcare spending is higher than any other industrialised nation,[2] but healthcare quality ranks last.[3]

In response, focus on value in the US healthcare system, defined as health outcomes achieved per dollar spent, has been intensifying.[4] In 2015, the Centers for Medicare & Medicaid Services set a goal to have 90% of healthcare reimbursement be value based by 2018, and commercial payers are following suit.[5 6] Health systems are beginning to respond by publishing their approaches to value-based care.[7–9]

By the beginning of 2014 it had become apparent that our own health system, NYU Langone Health (NYULH), had substantial opportunity to improve value. From 2010 to 2013, our institutional losses on Medicare patients had more than doubled. In 2013, we had been ranked number 1 in quality and accountability by the University Healthcare Consortium (now Vizient)[10]; however, the American Association of Medical Colleges-Council of Teaching Hospitals (COTH) quarterly survey of hospital operations and financial performance showed we were nearly at the 75th percentile for expense per discharge even after standardising for case mix index (CMI) and Wage Index.[11] Analytics from Cleverly and Associates, an external consultant, indicated that our CMI-adjusted Medicare loss per case was the highest among all academic medical centres.[12] It was in this environment that

Value Transformation at NYU

Institution-wide program with significant investment in creating joint clinical and operational leadership, data and cost accounting capabilities, a centralized project support staff, and a shared savings program.

Began in April 2014

Chatfield SC, Volpicelli FM, Adler NM, et al. *BMJ Qual Saf*. 2019;28(6):449-458.

ORIGINAL RESEARCH

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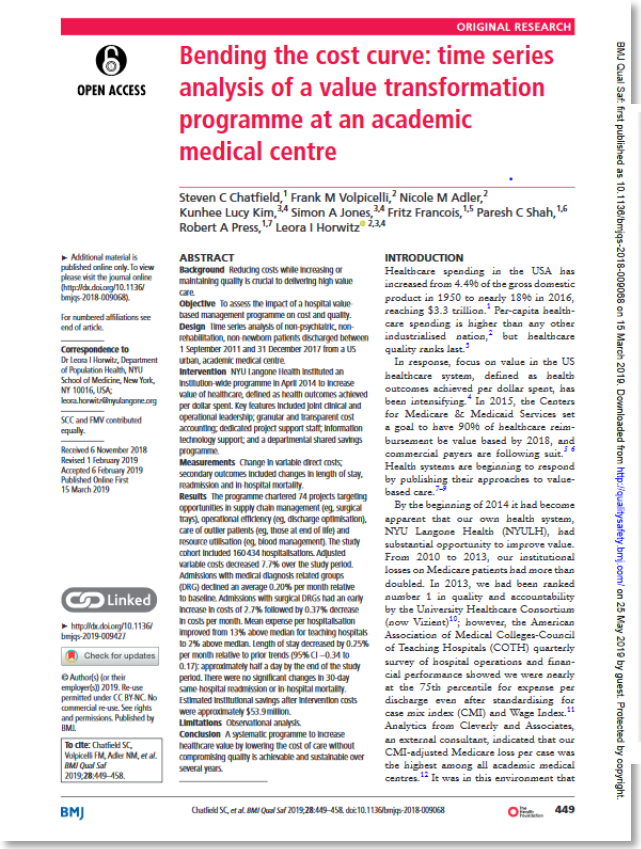
Value Transformation at NYU

Focused primarily on clinician-led projects (with a project manager co-lead) to decrease costs across six main domains:

1. operational efficiency,
2. resource utilization,
3. supply chain management,
4. revenue cycle,
5. outliers (highest cost patients),
6. corporate services (administrative and overhead costs)

74 projects in first 3 years!

Chatfield SC, Volpicelli FM, Adler NM, et al. *BMJ Qual Saf*. 2019;28(6):449-458.



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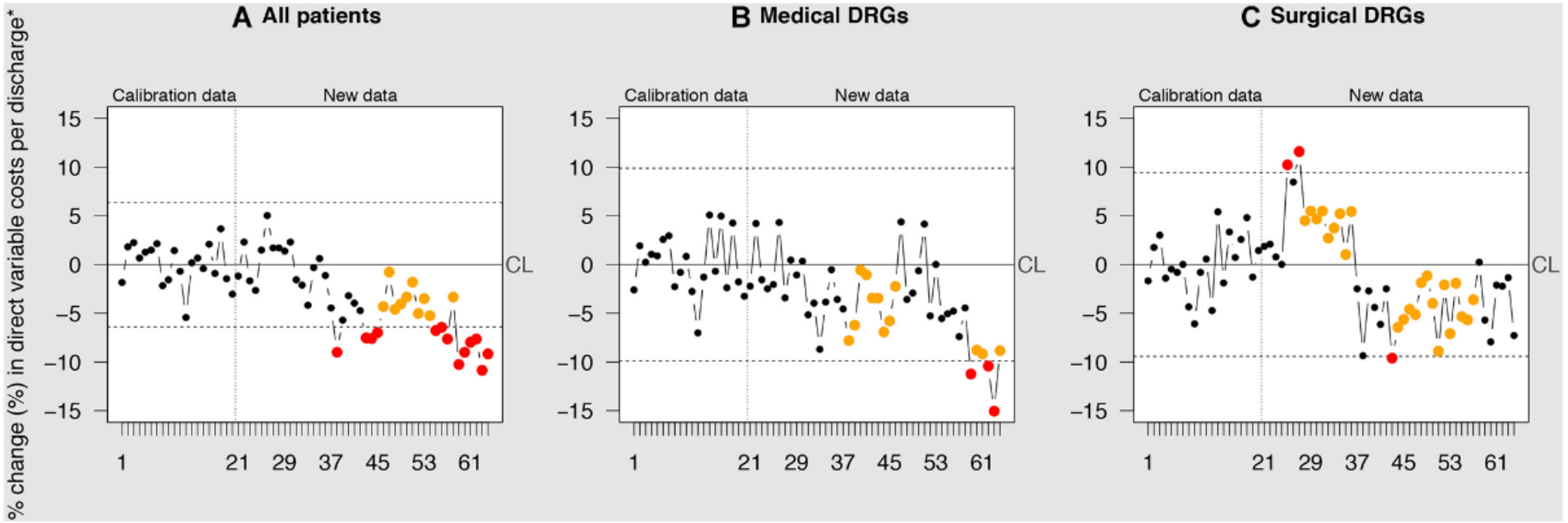

Total institutional net savings = $53.9 million over 3.75 years.

[This net savings estimate accounted for the cost of the program, which the authors report as $5.375 million over the study period.]

Chatfield SC, Volpicelli FM, Adler NM, et al. *BMJ Qual Saf*. 2019;28(6):449-458.

EDITORIAL

Emerging principles for health system value improvement programmes

Christopher Moriates,[1,2] Victoria Valencia[1]

[1]Internal Medicine and Medical Education, Dell Medical School at The University of Texas at Austin, Austin, Texas, United States
[2]Costs of Care Inc, Boston, Massachusetts, United States

Correspondence to
Dr Christopher Moriates, Departments of Internal Medicine and Medical Education, Dell Medical School at The University of Texas at Austin, Austin, TX 78712, USA; cmoriates@austin.utexas.edu

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Linked

Over recent years, hospitals have increasingly focused on improving value: outcomes achieved per dollar spent.[1] Although prior efforts to address costs and overuse in healthcare date back decades,[2] the modern movement in hospitals has largely progressed through overlapping stages, focused first on raising awareness and articulating the motivation for addressing costs and healthcare waste in education and care delivery.[3–9] Some hospital leaders began exploring the effect of simply providing cost transparency to clinicians, with limited results.[10 11] In concert with the launch of the 'Choosing Wisely' campaign in the USA in 2012, hospitalists led projects that largely sought to root out individual areas of overuse and 'things we do for no reason', ushering in a renewed emphasis on utilisation in hospitals.[12 13] Now, we have begun to see results from health systems that have created organisational value improvement programmes for hospitalised patients to simultaneously address both utilisation and costs, while measuring markers of quality and ensuring favourable patient outcomes.[14–16]

In this issue of *BMJ Quality & Safety*, Horwitz and colleagues[16] describe the impact of a large-scale, hospital value-based management (VBM) programme at New York University Langone Medical Center (NYU). The institution-wide cycle, outliers (highest cost patients) and corporate services (administrative and overhead costs). Over the first 3 years of the programme, they chartered 74 total projects, and saw a significant 7.7% decrease in adjusted variable costs, without measured changes in markers of quality including 30-day same-hospital readmissions and in-hospital mortality.

The authors estimated the total institutional net savings as a whopping $53.9 million over the 3.75 years since the introduction of the programme in April 2014. This net savings estimate of $14.3 million annually accounted for the cost of the programme, which the authors report as $5.375 million over the study period. A particular strength of this study is that Horwitz *et al*[16] explicitly calculated adjusted variable costs. Variable costs vary with the level of consumption, as typically occurs with supplies or medications. Reduce antibiotic prescriptions for asymptomatic bacteriuria and the health system realises true savings.[17] On the other hand, fixed costs for facilities and ancillary services generally persist despite reduced use. Therefore, reductions in lab tests or X-rays, or even length of stay, usually do not translate directly into savings the same way that consumable items such as medications do. Reducing average length of hospital stay does not produce concrete savings until the reduc-

Table 1 Key elements

Key element
Health system leadership explicitly identifies value improvement as a strategic priority.
Investment in robust cost and quality analytics and accounting systems.
Engagement of front-line clinicians in identifying and refining value improvement opportunities and priorities.
A centralised team for providing project support and coaching.
Regular feedback on performance at individual and/or group levels.
Dynamic leadership driven by accountability to strategic priority.

High Value Care CULTURE SURVEY

www.highvaluecareculturesurvey.com
(www.hvccs.com)

Table 2 High-Value Care Culture Survey factor characteristics

Factor	Number of items	Cronbach's α
Leadership and health system messaging	17	0.94
Data transparency and access	2	0.80
Comfort with cost conversations	3	0.70
Blame-free environment	2	0.70

Gupta R, Moriates C,Harrison JD, et al. BMJ Qual Saf. 26 Oct 2016 doi:10.1136/bmjqs-2016-005612

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To cite: Chatfield SC, Volpicelli FM, Adler NM, *et al*. *BMJ Qual Saf* 2019;**28**:449–458.

ABSTRACT

Background Reducing costs while increasing or maintaining quality is crucial to delivering high value care.

Objective To assess the impact of a hospital value-based management programme on cost and quality.

Design Time series analysis of non-psychiatric, non-rehabilitation, non-newborn patients discharged between 1 September 2011 and 31 December 2017 from a US urban, academic medical centre.

Intervention NYU Langone Health instituted an institution-wide programme in April 2014 to increase value of healthcare, defined as health outcomes achieved per dollar spent. Key features included joint clinical and operational leadership; granular and transparent cost accounting; dedicated project support staff; information technology support; and a departmental shared savings programme.

Measurements Change in variable direct costs; secondary outcomes included changes in length of stay, readmission and in-hospital mortality.

Results The programme chartered 74 projects targeting opportunities in supply chain management (eg, surgical trays), operational efficiency (eg, discharge optimisation), care of outlier patients (eg, those at end of life) and resource utilisation (eg, blood management). The study cohort included 160 434 hospitalisations. Adjusted variable costs decreased 7.7% over the study period. Admissions with medical diagnosis related groups (DRG) declined an average 0.20% per month relative to baseline. Admissions with surgical DRGs had an early increase in costs of 2.7% followed by 0.37% decrease in costs per month. Mean expense per hospitalisation improved from 13% above median for teaching hospitals to 2% above median. Length of stay decreased by 0.25% per month relative to prior trends (95% CI −0.34 to 0.17); approximately half a day by the end of the study period. There were no significant changes in 30-day same-hospital readmission or in-hospital mortality. Estimated institutional savings after intervention costs were approximately $53.9 million.

Limitations Observational analysis.

Conclusion A systematic programme to increase healthcare value by lowering the cost of care without compromising quality is achievable and sustainable over several years.

INTRODUCTION

Healthcare spending in the USA has increased from 4.4% of the gross domestic product in 1950 to nearly 18% in 2016, reaching $3.3 trillion.[1] Per-capita healthcare spending is higher than any other industrialised nation,[2] but healthcare quality ranks last.[3]

In response, focus on value in the US healthcare system, defined as health outcomes achieved per dollar spent, has been intensifying.[4] In 2015, the Centers for Medicare & Medicaid Services set a goal to have 90% of healthcare reimbursement be value based by 2018, and commercial payers are following suit.[5 6] Health systems are beginning to respond by publishing their approaches to value-based care.[7–9]

By the beginning of 2014 it had become apparent that our own health system, NYU Langone Health (NYULH), had substantial opportunity to improve value. From 2010 to 2013, our institutional losses on Medicare patients had more than doubled. In 2013, we had been ranked number 1 in quality and accountability by the University Healthcare Consortium (now Vizient)[10]; however, the American Association of Medical Colleges-Council of Teaching Hospitals (COTH) quarterly survey of hospital operations and financial performance showed we were nearly at the 75th percentile for expense per discharge even after standardising for case mix index (CMI) and Wage Index.[11] Analytics from Cleverly and Associates, an external consultant, indicated that our CMI-adjusted Medicare loss per case was the highest among all academic medical centres.[12] It was in this environment that

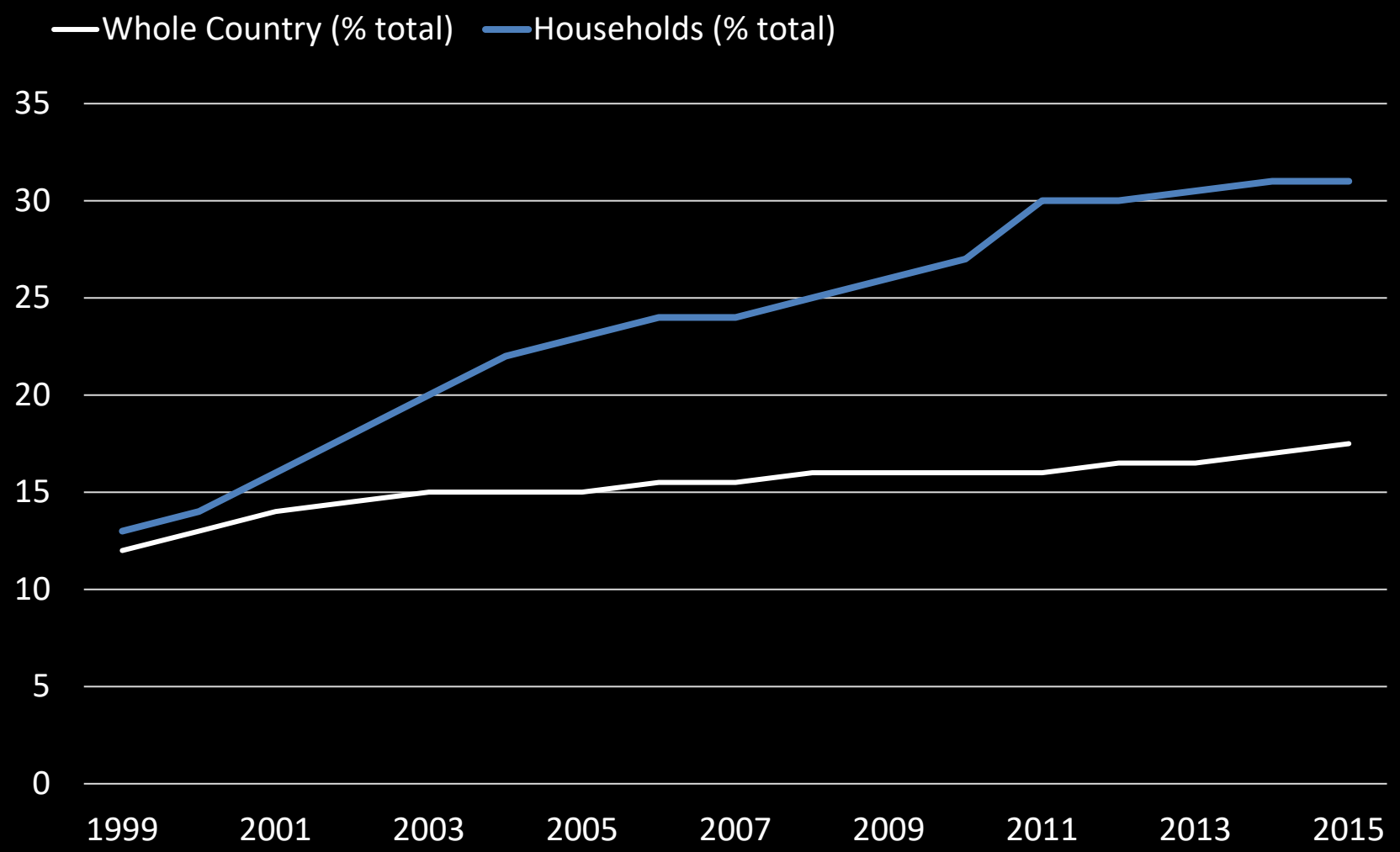
Total institutional net savings =

$53.9 million over 3.75 years.

Chatfield SC, Volpicelli FM, Adler NM, et al. *BMJ Qual Saf*. 2019;28(6):449-458.

Cutting waste in hospitals is NOT going to “trickle down” to patients

Moving from Total Costs to Affordability



Slide by: Neel Shah MD MPP, Costs of Care

AND….

What do we do when the care a patient needs is both NECESSARY and EXPENSIVE?

Health Care Value

Awareness

Appropriateness

Affordability

Foundation: Trust


Trust is built
on relationships.
ABIM
FOUNDATION

VIEWPOINT

TRUST IN HEALTH CARE

A Framework for Increasing Trust Between Patients and the Organizations That Care for Them

Thomas H. Lee, MD, MSc
Press Ganey, Boston, Massachusetts.

Elizabeth A. McGlynn, PhD
Kaiser Permanente, Pasadena, California.

Dana Gelb Safran, ScD
The Health Institute, Institute for Clinical Research and Health Policy Studies, Boston, Massachusetts.

Editorial page 547

Trust matters in health care. It makes patients feel less vulnerable, clinicians feel more effective, and reduces the imbalances of information by improving the flow of information. Trust is so fundamental to the patient-physician relationship that it is easy to assume it exists. But because of changes in health care and society at large, trust is increasingly understood to be at risk and in need of attention.[1]

The Problem

Trust is at risk because the US health care system has evolved in ways that (whether intentional or not) are de-prioritizing relationships. Today, trust must be based on more than patient-physician relationships because much of the state-of-the-science care requires groups of clinicians to work in teams, and patients must trust the overall team as well as its individual members.

Cultivating the trust of patients in the teams delivering their care would be simpler if those teams were well established, but many teams do not function well. Clinicians caring for a patient may not know or talk to each other, and all too often may just focus on the narrow areas of their expertise. However, there are exceptions such as multidisciplinary integrated practice units that are organized around patient conditions and take responsibility for patients across the continuum of care (eg, heart failure teams) and well-run and efficient ambulatory practices that do function as a team. The regularity of interactions among personnel and between the clinician and the patient provides the opportunity for the building of trust. Integrated practice units are becoming more common at larger medical centers, but still deliver only a small percentage of care.

Most clinicians have not cultivated the ability to form effective teams among personnel who may not have met before. However, examples of effective teams can be found on a daily basis in operating rooms where the use of the surgical checklist helps ensure that everyone introduces himself or herself and has the same understanding of the procedure to be undertaken. Even though many surgeons and other operating personnel were resistant to expectations that they use the surgical checklist when it was introduced, 93.4% (of 257 clinicians surveyed) indicated that if they were having a procedure performed on them, they would want the checklist used.[2] That insight helped operating room personnel understand that the checklist had cultural goals beyond the obvious immediate focus on safety issues. The checklist helped build the team's sense of shared purpose, and when clinicians imagined themselves as patients, they understood that such cohesiveness enhanced trust.

Another source of the problem is that the organizational structures within which these teams exist are changing rapidly. Organizations are merging, creating new structures, and adopting new names in place of those known to patients for decades, leading to the loss of familiar brands with trusted reputations. The merging process can also lead to changes in tangible and intangible aspects of the care experience that leave patients feeling like they have changed clinicians even when they are seeing the same clinicians but in a setting that looks, feels, and acts differently.

These types of changes put patients at risk for feeling untethered in systems that can seem bureaucratic, impersonal, uncaring, and unworthy of trust. These types of changes and their effects are also dispiriting for health care personnel, who tend to expect gratifying relationships with patients and colleagues. The reality is that the United States will not return to a delivery system model based on fewer specialties or more intimate care settings. Therefore, the challenge is infusing trust into the current delivery system care experience.

Solutions

There is reason for optimism. Research has identified factors that influence the development of trust, ranging from technical competency and interpersonal attributes to organizational factors. Physician behavior is especially critical; patients' trust is affected by their perceptions of physician empathy and honesty.[3] Trust correlates most highly with the patient's assessments of the ways physicians communicate, knowledge of the patient, and the interpersonal relationship. In contrast, trust is not highly correlated with the length of the patient-physician relationship or the patient's financial access to care.[4] According to 1 study,[5] most patients (>77% of 1578) reported that they completely or mostly trust their physicians "to put their health and well-being above keeping down the health plan's costs" even in the presence of incentives for efficiency.

Because of insights from such research, it is clear that trust can be measured directly and indirectly and it can improve as well as deteriorate. Health care organizations have business strategies that rely on patients being willing to trust them, and are therefore acquiring experience with data from patients that reflect on trust. Myths and facts about patient experience data are increasingly well defined[6] so that these data on trust can be assured and trust can be reestablished.

To identify and prioritize actions that will increase trust among patients and the organizations and teams that care for them, a work group of 17 health care leaders and patient advocates who were attending the 2018 American Board of Internal Medicine Foundation

Corresponding Author: Thomas H. Lee, MD, 53 State St, Boston, MA 02109 (thomas.lee@pressganey.com).

Public trust is a vital asset for clinicians and medical centers, crucial to keep patients seeking needed care, adhering to treatment, and achieving positive health outcomes.

Public Trust in Physicians — U.S. Medicine in International Perspective

Robert J. Blendon, Sc.D., John M. Benson, M.A., and Joachim O. Hero, M.P.H.

Over the past 60 years, public trust of physicians in the US (assessed as an aggregated group) has declined from 74% (1966) to 34%...

alongside declining trust in institutions.

N ENGL J MED 371;17 NEJM.ORG OCTOBER 23, 2014

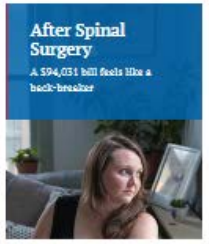
Attitudes about Doctors, by Country.*

Country	All Things Considered, Doctors in Your Country Can Be Trusted (Strongly Agree or Agree)		Satisfaction with the Treatment You Received When You Last Visited a Doctor (Completely or Very Satisfied)	
	rank	*% (95% CI)*	*rank*	*% (95% CI)*
Switzerland	1	83 (81–85)	1	64 (61–67)
Denmark	2	79 (77–81)	2	61 (59–64)
Netherlands	3	78 (75–80)	11	47 (44–50)
Britain	4	76 (73–79)	7	51 (48–55)
Finland	5	75 (73–78)	9	49 (46–52)
France	5	75 (73–77)	18	38 (36–40)
Turkey	5	75 (73–77)	15	41 (38–43)
Belgium	8	74 (73–76)	5	54 (52–56)
Sweden	8	74 (71–76)	10	48 (45–51)
Australia	10	73 (71–76)	4	55 (52–58)
Czech Republic	10	73 (71–75)	16	39 (36–41)
Norway	12	72 (70–74)	5	54 (51–56)
Taiwan	12	72 (70–74)	27	17 (15–18)
Slovenia	14	70 (68–73)	14	44 (41–47)
South Africa	14	70 (68–72)	7	51 (49–54)
Portugal	16	69 (66–72)	23	26 (23–29)
Philippines	17	68 (65–71)	16	39 (36–42)
Israel	18	67 (64–70)	12	46 (43–49)
Germany	19	66 (64–68)	12	46 (44–48)
Slovakia	20	62 (59–66)	22	28 (24–31)
South Korea	20	62 (60–65)	24	25 (23–28)
Lithuania	22	61 (58–64)	28	13 (11–15)
Japan	23	60 (57–63)	20	30 (27–33)
Croatia	24	58 (56–61)	19	31 (28–34)
United States	24	58 (55–61)	3	56 (54–59)
Chile	26	56 (52–59)	25	23 (20–26)
Bulgaria	27	46 (43–49)	20	30 (27–33)
Russia	28	45 (42–48)	29	11 (9–13)
Poland	29	43 (40–46)	25	23 (21–26)

* Respondents who answered the satisfaction question "does not apply" were not included in the denominator. Countries are rank-ordered according to the percentage of respondents who said they strongly agreed or agreed that "All things considered, doctors in [your country] can be trusted." Countries with the same rank were tied on that measure. CI denotes confidence interval. Data are from the International Social Survey Programme, 2011–2013.

Bill Of The Month

This crowdsourced investigation by Kaiser Health News and NPR dissects and explains your medical bills every month in order to shed light on U.S. health care prices and to help patients learn how to be more active in managing costs. Do you have a medical bill that you'd like us to see and scrutinize? Submit it here and tell us the story behind it.



SEND US YOUR MEDICAL BILL

Do you have an exorbitant or baffling medical bill? Join the KHN and NPR "Bill of the Month" Club and tell us about your experience. We'll feature a new one each month.

KHN | npr

SUBMIT YOUR BILL

BILL OF THE MONTH RESOURCES

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A $20,243 bike crash: Zuckerberg hospital's aggressive tactics leave patients with big bills

I spent a year writing about ER bills. Zuckerberg San Francisco General has the most surprising billing practices I've seen.

By Sarah Kliff | sarah@vox.com | Updated Jan 24, 2019, 4:27pm EST

He went to an in-network emergency room. He still ended up with a $7,924 bill.

You can't avoid surprise medical bills even with a "PhD in surprise billing."

By Sarah Kliff | sarah@vox.com | May 23, 2018, 6:00am EDT

Graphic by Kavya Sukumar

SHARE

Part of **Hospitals kept ER fees secret. We uncovered them.**

On January 28, 34-year-old Scott Kohan woke up in an emergency room in downtown Austin, Texas, with his jaw broken in two places, the result of a violent attack the night before. Witnesses called 911, which dispatched an ambulance that brought him to the hospital while he was unconscious.

"The thing I remember most was my lips were caked in blood and super dry," Kohan says. "My head was throbbing, so I touched the top of my head, and I could feel staples there."

Kohan called for a nurse, who explained that he would need jaw surgery that night. In the meantime, he tried to check whether the hospital — Dell Seton Medical Center — was in his insurance network.


AFFORDABILITY
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THEIR **LIFE** AND THEIR **LIFE-*SAVINGS***

www.moonshot.costsofcare.org

Costs of Care @CostsofCare · Jan 9

"I envision a world in which no one has to choose between getting needed health care or meeting their other basic needs - things like groceries, housing, and utilities." - @choo_ek, MD, #CoCMoonshot #lifeoverlifesavings - Share your healthcare world now: moonshot.costsofcare.org

You and 7 others

1 15 57

JOIN US AND TOGETHER LET'S LEAD A MOVEMENT TO CREATE A WORLD WHERE NO ONE HAS TO CHOOSE BETWEEN THEIR LIFE AND THEIR LIFE-SAVINGS.

WE envision a healthcare world in which...

"We use our resources wisely to maxi quality of life keepi gov regs down and increase competition."
Donald Bouton
Saint Louis, MO

"my patients will not have to ask "How much will that cost?" for life-saving treatments."
Nicholas Gavin
New York, NY

"I won't be financially ruined by accessing highest quality care"
Nancy
New York , New York

"medical care didn't require use of my savings and 401k for basic necessities and to keep my house!"
Sharon Rose Nissley
Chicagoland, IL

"patients get all the care they need and none that they don't"
Tim Hannon
Indianapolis, IN

"I can say "No way" when asked to pay a bill for healthcare services where I was harmed in any way!"
Poppy Arford
Brunswick, ME

"Everyone should be able to get best possible treatment with whatever they can afford to pay."
Dipika Shah
Holmdel, Nj

"there are no financial and bureaucratic borders between the care I give and the patients I see!"
Yalda Afshar
Los Angeles, California

"each patient is treated properly and timely based on their individual needs & symptoms"
Barby Ingle
San Tan Valley, AZ

"an individuals' entire life saving isn't wiped out by a single diagnosis"
Charlie Wray
San Francisco, CA

"all players in the health care ecosystem work together rather than point fingers at each other"
Samyukta Mullangi
New York, NY

"patients don't have to choose between paying for health care and feeding their family."
Kshitij Thakur

"Cost transparency is baked into the healthcare system – no price for me without me."
Casey Quinlan
Richmond, VA

"Patients can come to appointments without worrying about the hospital parking fee."
Arjun Gupta
Baltimore, MD

"hospitals don't sue their patients for unpaid bills."
Fumiko Chino
New York, NY

"Every american has access to affordable care without having to trade off financial necessities."
Jordan Harmon
New York, NY

"Cost transparency is

THE STEVEN SCHROEDER AWARD

for

Outstanding Healthcare CEO

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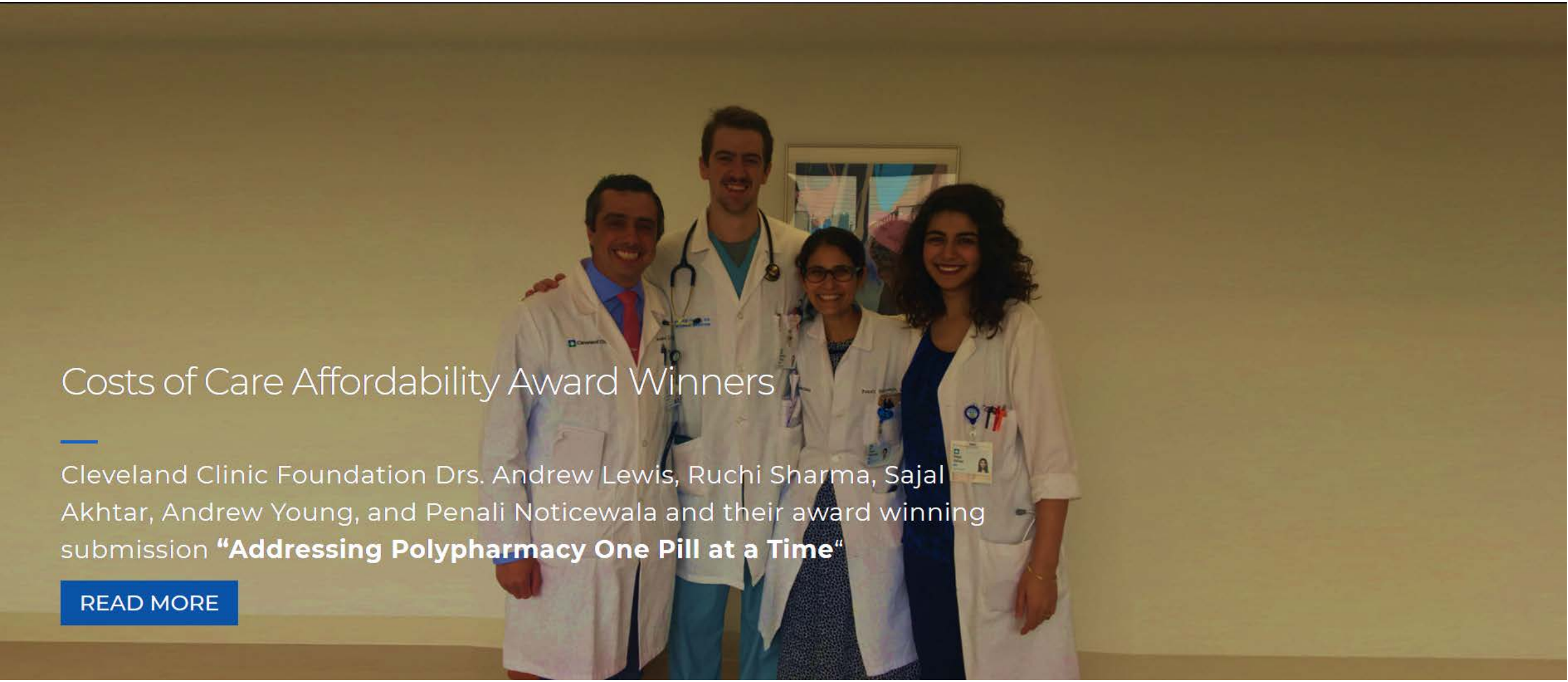

Costs of Care Affordability Award Winners

Cleveland Clinic Foundation Drs. Andrew Lewis, Ruchi Sharma, Sajal Akhtar, Andrew Young, and Penali Noticewala and their award winning submission **“Addressing Polypharmacy One Pill at a Time“**

READ MORE

New Marketplace

The Next Frontier in Reducing Costs of Care: Patient Affordability

Reshma Gupta, MD, MSHPM, Jordan Harmon, MHA & Patrick H. Conway, MD, MSc

Costs of Care

Blue Cross Blue Shield of North Carolina

Article · August 22, 2019

AFFORDABILITY MOONSHOT
POWERED BY COSTS OF CARE

AFFORDABILITY ACCELERATOR

This Affordability Moonshot campaign sets the stage for our Affordability Accelerator, in which we will convene **influential experts and stakeholders to work together on developing, testing, and implementing** the most promising high-impact and sustainable interventions to improve patient affordability.

Our Affordability Accelerator will take place in Spring 2020 and will be a unique opportunity for those interested in being at the forefront of the patient affordability movement to make a significant contribution to our shared work together on developing solutions that will make meaningful differences for patients.


Tools you can use
to learn and teach high-value care

Professionalism as the Bedrock of High-Value Care

Marcotte, Leah M. MD; Moriates, Christopher MD; Wolfson, Daniel B. MHSA; Frankel, Richard M. PhD

Academic Medicine: July 2, 2019 - Volume Publish Ahead of Print - Issue - p
doi: 10.1097/ACM.0000000000002858
Perspective: PDF Only

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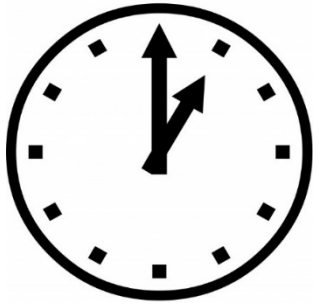
vbhc.dellmed.utexas.edu

Collection	Modules
Introduction to Health-Care Value	1-3
Value Based Health Care Delivery	4-5
Improving Value at the Bedside	6-7
Improving Value in Systems	8-10



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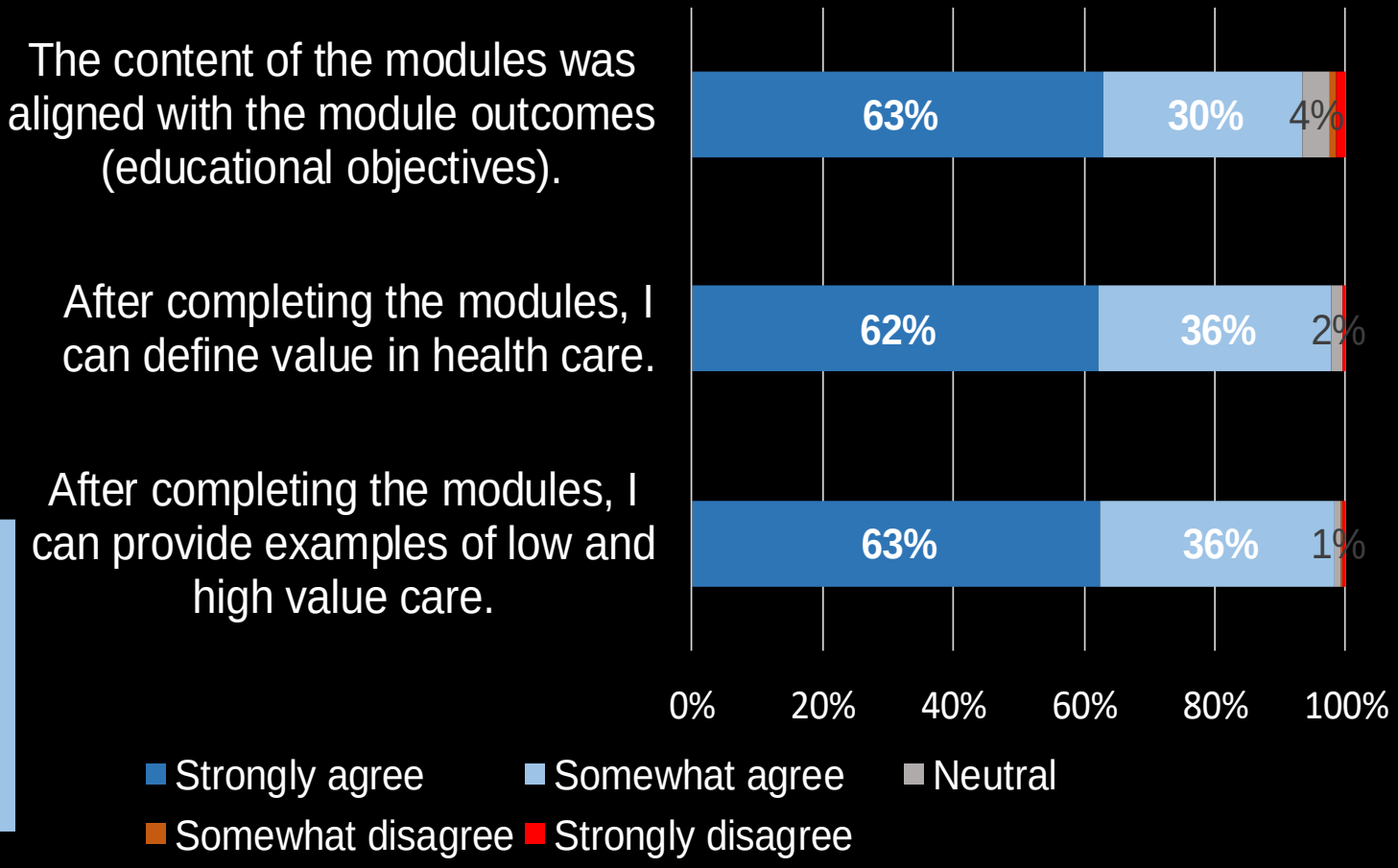

ACADEMIC MEDICINE
Journal of the Association of American Medical Colleges
AAMC

< Previous Abstract | Next Abstract >

Using Interactive Learning Modules to Teach Value-Based Health Care to Health Professions Trainees Across the United States

Moriates, Christopher, MD; Valencia, Victoria, MPH; Stamets, Sara, MA; Joo, Joseph; MacClements, Jonathan, MD; Wilkerson, LuAnn, EdD; Nelson, Elizabeth A., MD; Bozic, Kevin, MD, MBA; Cox, Susan M., MD

Academic Medicine: February 19, 2019 - Volume Publish Ahead of Print - Issue - p
doi: 10.1097/ACM.0000000000002670
Innovation Report: PDF Only

www.vbhc.dellmed.utexas.edu

The University of Texas at Austin
Dell Medical School

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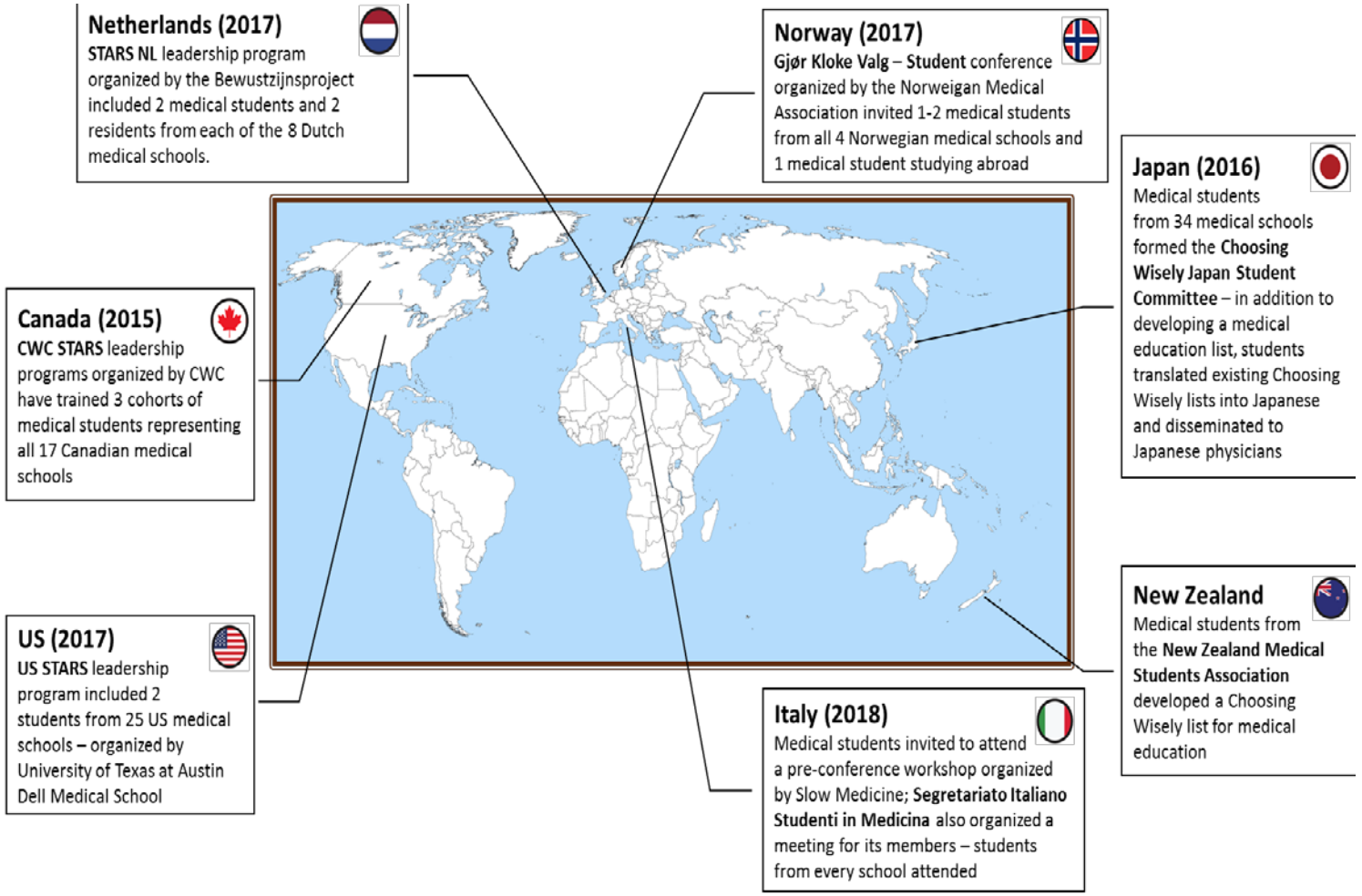
COSTS of CARE

Learners as Leaders: A Global Groundswell of Students Leading Choosing Wisely Initiatives in Medical Education

Karen B. Born, PhD, Christopher Moriates, MD, Victoria Valencia, MPH, Marlou Kerssens, MSc, and Brian M. Wong, MD, FRCPC

ACADEMIC MEDICINE



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(Some) Conclusions

Medical centers and clinicians should **strive to ensure** that **no patient has to choose** between their life and their life-savings, **rebuild trust** with patients through **authentic and measurable** efforts, and help them achieve **the best possible health outcomes at a price they can live with.**

A WORLD IN WHICH NO ONE HAS TO CHOOSE BETWEEN

THEIR **LIFE** AND THEIR **LIFE-*SAVINGS***

www.moonshot.costsofcare.org

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Chris Moriates, MD

@ChrisMoriates

Cmoriates@austin.utexas.edu