Center *for* Rural Health

What is Value Based Care? What Does It Mean to Me?

Presented to Grand Forks Lions Club

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Center *for* Rural Health
University of North Dakota
School of Medicine & Health Sciences

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- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

Focus on

- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

- US Health Care System is changing –rather significantly.
- Why:
  - We spend more than any other country.
  - $4.3 Trillion.
  - $12,900 per person (Germany $6,700 Canada $5,400)
  - 18% US GDP, Germany 11%, Canada 11%, GB 10%
  - But our outcomes are worse
    - US ranks 47th in life expectancy (Czeck Rep is 46th Croatia is 49th
    - US 79.74 years and Hong Kong at #1 in LE is 85.83 years
    - Highest chronic disease rate.
    - Highest suicide rate
    - Highest rate of obesity
    - Compared on a series of measures, the Commonwealth Fund has found the US ranking last in comparison to Netherlands, Norway Germany, Sweden, UK, Canada, Auz, NZ, SWZ, and FRA

- So we spend more and get less.
- Much of US health policy revolves around two goals**: Increase access and control cost.** Do they work against each other**.**
- **Quick Review of Key US Health Policy**
  - Medicare and Medicaid -1964
  - Wage and Price Control -1970,
  - Health Planning Agencies and Certificate of Need – mid 1970's (ND had 3 federally supported HPA, ended about 1985
  - HMO Act -1973
  - PPS and DRG -1983
  - Medicare Modernization Act -2003 (created privatization of Medicare)
  - Affordable Care Act -2010- Marketplace, insurance reform, CMMI

- **Back and forth policy struggle to meet complicated health policy goals. (Again, result: spend more than others and outcomes are poorer)**
- **Where does the money go?**
    - Hospitals -31%
    - Phys -15%
    - Other clinical -5% so **51% is in medical care system**
    - Pharm -9%
    - NH -4%
    - **Who Pays**
    - Private -28%
    - Medicare-21%
    - Medicaid -17% so **Medicare/Medicaid 38%**
    - Out of pocket -10%

- **Other changes – Who are these other players in Health Care – Is that Amazon?**
  - Health Care providers are used to other HC in the market but now there are new businesses coming in –Walmart, Amazon, Target, Walgreen, CVS
  - Buying up PC practices with 500, 800, 1000 and more PC docs.
  - **Walgreen** in Sept 2023 signed an agreement with Pearl Health (provider) in 29 states, 800 physicians –Pearl does risk contracting.
  - **Caravan Health** (a rural based ACO) was bought by Signify Health a larger ACO for $250 m in March 2020 and by September 2020 Signify Health was bought by CVS for $8 billion.

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- **CVS** announced it will put $65 B into health care purchases by 2030 including $185 million to develop housing – 6,400 units in 65 cities in 28 states.
- **Private Equity firms** too – since 2013 PE has acquired over 1000 practices. Up to 40% of ED are staffed by PE physicians.
- Private Equity are legal operations –do their values (seemingly strictly profit) match well with health goals of improved health, better care, and controlled cost? Legitimate question.

- Why? Willie Sutton joke. It is where the money is.

- What I really want to talk about is something that many of us feel is a potentially very positive change in Health Care that can benefit patients to get at this need to improve care yet address costs– **Value Based Care**
- **But REVIEW: So we spend more than other countries yet our health outcomes are worse.**
- **We have experimented with many ways to try to expand access yet control cost – and we spend over $4 T**
- ***Maybe, just maybe another way to look at our system is to change the incentives.***
- **We incentivize every step in the health care process – more tests, more exams, more treatment and everything has a dollar assigned. The more you do the more money you get. Start to see how costs go up.**

- So can we change the incentives from the more you do the more you are paid (regardless of patient improvement) to one where there are incentives for improved outcomes.
- Going from a **volume based to value based – outcomes-impact- positive change for the patient**–not how many or how much but what improves – quality.
- We are trying to move from a **sick based** care system to a wellness or **well care** system.
- **Key Concepts – Population Health, Health Equity, Health Disparities, and SDOH.**
- Improve the quality of patient care and pay for that.
- Rely less on fee for service but still have a base of it (likely will never fully go away) although there are models being implemented that do not use fee for service.

- **Rely heavily on primary care** and others – certainly still specialists but if we can help people to stay well it costs less – prevention and wellness.
- Lessen the need for inpatient care and certainly readmissions and also unnecessary use of the ED.
- Providers are held **accountable for the care**. ACO upside and downside risk – Upside is if they meet their care targets for patients (metrics) they share in the savings. And if they do not they are held harmless. However, with downside risk if they miss the target they are penalized. Incentivize risk. This is where health care is headed.
- Care metrics can be following and meeting clinical guidelines but also patient satisfaction, readmission rates, LOS and other – clinical could be A1C numbers for diabetes

- **So what are some of the key parts of VBC to get to well care?**
  - Annual wellness visit – very important, not like an annual physical
  - Care coordination, care management
  - Motivational interviewing – wellness coach, coach you not tell you
  - New provider types – care coordinators, CHW, community paramedic
  - Dave Momen story –poverty –SDOH – housing, income, education, type of job, transportation, race/ethnicity, health literacy, physical environment, ability to make good health decisions (individual responsibility)
  - **DATA, DATA DATA –** Signify Health Coach Demo Population Health dashboard. – numerous metrics on patient. nurse can see what patient struggles with or is successful. Ex: 70 years old and does exercise, but does not drive on ice. Check to see if they need a ride. Do you need to connect them with housing? Connect them with a way to get vegetables.

- Community engagement – address SDOH via partners –hospital and clinic cant do it all.

- **Models**
  - ACO about 1000 in operation –public and private
  - Close to 500 are Medicare Shared Savings. Most common
  - Other models: Bundled Payments, Global budget, All Payor System, Total Cost of Care is the most advanced.
  - ND 65% of our CAHs in a Medicare SS program – Signify Health
  - Nationally about 1/3 of CAHs are in an ACO
  - BCBSND has ACO model –Blue Alliance (3 tier, 3rd is downside risk)

- **Summary**
  - Spend more than others yet outcomes are significantly worse.
  - Health policy address increasing access and cost control – values but policy conflict?
  - Emphasis is moving from volume to value, moving from sick care to well care
  - Key concepts of Population health, health equity, SDOH – our lives influence our health more than medical system.
  - Incentives are changing from rewarding more to rewarding results – again volume to value
  - Triple (Quadruple) Aim
  - Greater reliance on primary care
  - This may make a better health system –preliminary data –slowing costs and improving quality.
  - Time will tell.
  - Churchill- “Americans can be relied upon to do the right thing…after they have exhausted all the other options.”

Contact us for more information!

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