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Population Health NEWS

Thought Leaders' Corner

By its very definition, value-based care represents a fundamental shift in concentration from volume to outcomes. This new focus adds a level of accountability not present in a fee-for-service environment, where "more" has historically, and often misleadingly, been viewed as "better." The value-based care model calls for more appropriately managing the totality of a patient's conditions—not just individual symptoms—and by doing so provides a direct incentive to ask what the right care is (and in what setting) for this patient and how we might eliminate redundant or questionable treatments that add little or no value to the patient. By making sure resources are being properly managed and all conditions and diagnoses that influence a patient's core health are being addressed, value-based care can play a major role in improving population health.

Value-based care puts a premium not on volume but on managing to a desired patient outcome. Around the country we have already seen multiple examples of how this shift in mindset and incentives has been able to reduce or eliminate unnecessary, and sometimes inappropriate, services and tests; control avoidable and unnecessary emergency room visits and inpatient stays; and encourage the use of innovative approaches and technologies such as individual care coordination and telehealth. All of these attainments are consistent with the goals of population health, which aims to mitigate costs by focusing on appropriate utilization of services to manage and coordinate care efficiently and to prevent chronic diseases.

Value-based care also helps attain the gallant goals of the triple aim by shining a spotlight on providing the right care in the right setting at the right time. When most effective, value-based care places increased emphasis on appropriate and necessary utilization of services, eliminating instances of both over- or under-utilization that generally trigger increased cost to the patient and the system while often offering very little true value as it relates to improved outcomes.

The crusade to value-based care by both private and public payers is not a trend that is expected to end anytime soon. It's just the opposite. The move to concentrate on a payment methodology that encourages focus on a patient's global condition has jumped into the mainstream and has manifested itself in many ways. Health plans have been at the forefront of value-based payments for years, and many now consider it a fundamental part of how they conduct business. So, too, several large physician groups and integrated delivery systems have successfully, and profitably, accepted capitated payments to care for a broad, diverse population of patients.

The federal government has recognized the value in value-based care as well. For that, one needs only to look at CMS "experimentation" with bundled payments and other methodologies that was expressly designed to foster innovation and creativity in comprehensive care for Medicare patients. The agency's innovation center recently announced an expanded commitment to value-based payment models for primary care practices, both small and large. This redesign of the fee-for-service payment model is intended to share the rewards of value-based care with physicians, with a strong foundation on significant quality measures. Though initially concentrated in Medicare, CMS hopes to extend these new payment models to Medicaid programs as well.

While the expectation may be that these value-based care methodologies will ultimately save health care costs, the true measure of success will be if patients achieve better outcomes, see real quality improvement and commit to receiving their care under this new system. That sounds a lot to me like what the champions of population health are seeking as well.

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