2017

Teaching Value-based Care: A Framework for a Family Medicine Resident Clinic

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Family Medicine Community Project
Rotation 3: 06/26/2017- 08/11/2017
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LARNER COLLEGE OF MEDICINE

Problem Identification

- Department of H&HS set a goal of tying 30% of Medicare payments in alternative payment models (i.e. value-based care) by the end of 2016, and 50% by the end of 2018. (1)
  - UVMMC plans to tie 80% of its payment to quality of care by 2018. (2)
- Among graduating U.S. medical students, less than half felt they were appropriately trained in topics relating to the practice of medicine such as medical economics. (3)
- Multiple professional medical societies have recognized these deficits in medical education; however, teaching hospitals and residency programs currently lack a clear, common strategy to teach "value." (4)
  - Teaching these concepts requires a multi-disciplinary faculty not abundantly available at many institutions, and there is a general lack of research on best methods for curricular development in this area.
- In 2010, the Medicare Payment Advisory Commission (MedPAC) proposed to reallocate over 1/3 of the current $9.5 billion of Medicare funding towards Graduate Medical Education (GME) as performance-based payments, rewarding residency programs that educate physicians on the basis of the following: *integration of community-based care with inpatient care, practice-based learning and improvement, and systems-based practice*. (4, 11)
  - In the future, academic medical centers' may be paid on value with penalties for lapses in safety and quality education. (12)

Public Health Cost

- Healthcare costs in the United States are increasing at an unsustainable rate: $253 billion in 1980 to $714 billion in 1990 to nearly $2.7 trillion in 2014. (5)
  - ~30% of healthcare costs (more than $750 billion annually) are wasted care, care that is potentially avoidable and would not negatively affect the quality of care if eliminated.
- In February 2017, the state of Vermont embarked on a one-year, $93-million pilot project using a value-based, shared-savings payment model, as opposed to a fee-for-service one. (6,7)
  - ~30,000 of Vermont's Medicaid enrollees will receive care through this project, meaning each patient is allotted ~$3,100 in care.
  - If OneCare Vermont, the accountable care organization administering the program, spends more than $93 million, the company will absorb the loss. If OneCare spends less than that amount, the company and the state share the savings.
  - The Medicaid patients participating in the program will come from the regions served by four community hospitals: Porter Medical Center in Middlebury, UVMMC in Burlington, NWMC in St. Albans, and CVMC in Berlin. (8)
    - *> 90% Milton Family Practice's patients come from UVMMC or NWMC.*
- Vermont will encourage Vermont payers and providers to participate in Accountable Care Organizations (ACO) programs such that by 2022, 70% of all Vermont insured residents, including 90% of Vermont Medicare beneficiaries, are attributed to an ACO. (9,10)
- Medicaid covers almost 32% of Milton Family Practice patients, while Medicare covers roughly 50%.

Community Perspective

John King, MD, MPH

Professor and Vice Chair of Academics and Regional Development, Department of Family Medicine

What are the challenges in providing more training in health economics as it pertains to graduate medical education and beyond?
"Physicians have been almost completely insulated from the costs of care, so there is virtually no one to teach this. Physicians may not need training in health economics, but they mostly need to focus on evidence based medicine. Value based payment reform will change physician behavior as long as incentives move away from fee-for-service. The perverse incentives are what is driving most of the cost."

Why is it important to prepare current healthcare providers-in-training for a value-based health economy?
"A value based system is the right thing to do to be able to provide medical care to the most patients. It is also essential if our country is going to be competitive in a world market."

How could educating providers on value-based care improve the health outcomes of the served community?
"Education won't (necessarily) help, but changing the way we are paid will. When Fee-for-Service goes away we won't have to see 20 patients a day to make ends meet and we can innovate with telemedicine, nurse and physcian provided phone medicine, evidence based protocol driven chronic disease and preventive care that is not tied to office visits and procedures."

Hollie Shaner-McRae, DNP, RN, FAAP

UVMMC Clinical Documentation Integrity Program

Collaborator, Value-based Purchasing Pilot Model at Milton Family Practice

What does it mean to understand "value" in healthcare?
"The same thing it means to understand value in any purchased service. Are we getting value for our investment? I would argue that there have been such 'veils' put in place in our current fee for service, cost shifting model, that even for someone like myself with a doctorate, it is very difficult to understand what it really costs for an office visit, lab tests, and more."

Why do you think it has been so hard to offer educational sessions on the economics of healthcare value?
"a) Schedules are already exceedingly full.
b) The 'target' and rules are seemingly constantly in flux, creating a lot of complexity and nuance.
c) Focus has traditionally been on delivery of care; consequently, it is almost taboo to discuss its financing"

Why is it important to prepare current healthcare students for a value-based health economy?
"It's important to understand the framework within which one practices and the external 'rules' applied to that framework by agencies that provide the funding. It is essential that healthcare students recognize that the clinical aspects they are learning through faculty and mentors may not sync up with the realities of externally imposed reimbursement methods…Having a knowledge deficit in this domain of healthcare leads to provider frustration, and ultimately creates a lot of unnecessary 'rework' for providers.

Intervention & Methodology

- First, I conducted a literature review to understand current pedagogical methods aimed at teaching resident-physicians how to assess and deliver value-based healthcare.
- Second, I discussed efforts and strategies to implement value-based education exercises into the UVM family medicine residency program with faculty, staff, and residents.
- Third, I prepared a simple, easy-to-implement framework for both residents and faculty to apply in Milton Family Practice during precepting.

Results

- Milton Family Practice (MFP) is home to the University Vermont's Family Medicine Residency program.
- MFP can use this mnemonic framework to incorporate concepts of value-based care into everyday practice for residents and even faculty.
- This table will be posted in the "TA" room and resident work station at Milton Family Practice, where resident physicians present patient cases to attending physicians. (4)
    - Case examples demonstrate opportunities for residents to practice and learn these principles.

The VALUE Framework	Description	Case Examples
Validation & Variability	• The initial step for a resident to evaluate whether a medical intervention will provide value for a patient is to determine if it has been validated through evidence-based medicine from rigorous research trials or if it has been used despite weaker evidence. • Understanding variability is of utmost importance when attempting to apply the outcomes of population-based research to individual patients. Certain medications may be very effective in a specific cohort, but individual differences in age, ethnicity, comorbidities or behavior can greatly affect the benefits of an intervention. It is also important to recognize the variability of diagnostic tests, interventions and outcome measures.	• Pick one patient a week that is considering a medical intervention and compare at least two published studies regarding the validation of study measures and the variability of their application across study populations. Residents then discuss with the group how their findings relate to the patient
Affordability & Access	• Evaluating whether a medical intervention is affordable for a patient is important for two reasons: First, patients are more likely to adhere to interventions that are less expensive, such as when generic medications are compared to brand names. Second, no care translates into no value for the patient. • Teaching residents how to best identify resources or alternative treatments can lead to improved value for patients—including in situations when not intervening may provide the most value of all. • Limited access to medical care can create barriers to maximizing value from a medical intervention. Residents who can better identify practice settings or patient populations at risk for limited access to care have been found to be better prepared to provide appropriate counseling to patients.	• Ask each patient how they pay for their medical care and medications. Ask uninsured patients how they are finding opportunities to seek medical attention when needed. Ask all patients who express concerns about affordability and access if they are willing to meet with a social worker to understand options for support
Long-Term and Less side Effects	• When evaluating a patient, residents should remember to consider the long-term horizon to recognize medical interventions that might lead to lasting benefits. • Side effects from interventions such as medications can impact adherence and sometimes worsen a patient's quality of life. Side effects differ from adverse events in that they are known and predicted consequences of medication or intervention. Side effects are often known at time of medical decision making and should play a role in determining which intervention has a lower likelihood of side effects and might provide more value.	• When discussing care options with patients in the outpatient setting, always discuss short-term and long-term effects of an intervention, including side effects. Discuss continuing current management without intervention as an option
Utility and Usability	• The balance between utility and usability is important when considering whether an intervention will provide value. Medical utility refers to the desirability of a health outcome. Usability refers to the patient's willingness and ability to adhere to the intervention.	• Regularly ask patients about their recent and past health status to better understand trends over time. When evaluating an intervention discuss the usability (e.g. ease of use, frequency, affect on patient's daily living) and the impact on a patient's utility (e.g. potential to improve their health status).
Effectiveness and Errors	• Interventions that work within controlled settings are defined as efficacious. However, efficacy does not always translate into similar effective outcomes in real-world settings. • When reviewing published studies on medical interventions, one must carefully evaluate whether the outcomes were shown to be effective and apply to the patient since many differences between efficacy and effectiveness are due to variations in patient populations or differences in settings.	• Utilize evidence-based clinical guidelines (e.g. USPTF) when evaluating the effectiveness of screening tests. Health systems can also encourage residents to report errors and be involved in quality improvement initiatives

Evaluation of Effectiveness & Limitations

Effectiveness

- The VALUE Framework provides a simple and concise method for residents to assess whether an intervention might create value for their patients. (4)
  - Health care providers that start to develop VBC models now may gain early advantages that will enable them to compete more effectively in the future.
- The VALUE Framework is aligned with all six general competencies set forth by the Accreditation Council for Graduate Medical Education and with the proposed 7th competency of providing high-value, cost-conscious care.
- Opportunities for the UVM Family Medicine residency program to use and test this framework within structured and clinical teaching, measurement, evaluation, and feedback might lead to further improvements in training residents to provide value-based care.

Limitations

- Difficult to measure the effect of this framework on patient outcomes.
- Did not survey current residents to assess their level of understanding of "value-based care" prior to intervention.
- Potential lack of adoption by faculty and residents
- Isolated learning exercise
  - To achieve a more meaningful impact, a systematic approach must be taken to match fundamental training in value-based care to the teaching dynamics within residency programs. The process of teaching residents involves several stages in various clinical and non-clinical settings. (4)
- General lack of research on best methods for curricular development in this area

Recommendations for Future Interventions

- Post-encounter survey patients' on whether they felt they received value care based on the five components of the "VALUE" Framework.
- UVM family medicine residency program may incorporate a pre- and post-residency survey to gauge residents' understanding of value-based care.
- Online training modules that teach value-based care principles
  - ACP Version 3.0 of the High Value Care Curriculum for Internal Medicine Residents (13)
  - "Teaching Value in Health Care Learning Network" (14)
- Systematic opportunities to use and test this framework within structured and clinical teaching, measurement, evaluation, and feedback (4)
  - Structured Teaching: e.g. journal club, rotation projects, grand rounds, quality improvement curriculum
  - Clinical Teaching: e.g. bedside interactions, "staffing" patients, social work rounds, discharge planning
  - Evaluation: e.g. online evaluation modules, senior resident evaluations
  - Feedback: e.g. data-driven report cards

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Interview Consent Form

- Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview. Yes __X__ / No _____ If not consenting as above: please add the interviewee names here for the department of Family Medicine information only.