It’s time to take a pragmatic approach to value in healthcare. That’s what Ethan Berke, MD, MPH, chief medical officer of population health solutions and vice president of clinical innovation at Optum, thinks.

On the frontlines working with providers and large payers across the health system, Dr. Berke has continually challenged preconceived notions of what value looks like. He joined Optum after serving as the medical director of clinical design and innovation at Dartmouth-Hitchcock Health System. At D-HHS he was also chief medical officer of ImagineCare, a 24/7 nurse-led, coordinated care model that leverages remote medical sensing and machine learning analytics.

Given his unique position of working with organizations to collaborate across the health system, Becker’s Hospital Review recently asked Dr. Berke to share his perspectives on best approaches for creating value in healthcare.

What does value really mean today?

In healthcare, the term value can carry a different meaning depending on who you ask. At its essence, value is about delivering the highest quality of care at the most reasonable cost.

“It’s a two-way street,” Dr. Berke says. “Value is present in healthcare when patients feel they received a service that was meaningful and appropriate, and providers feel they delivered care aligned with their mission and training.”

The biggest misconception about value is that it is often conflated with only risk-based delivery models. “Not so,” says Dr. Berke. He believes high value care is possible regardless of the reimbursement model in which payers and providers are operating. “It’s a principle that transcends all different payment models.”

“Even fee-for-service organizations aren’t immune from risk in some of their patient populations,” Dr. Berke points out. “Consider when a health system’s employees are covered by the system’s employer-sponsored health plan, or if the health system treats self-pay patients with a lower rate of payment recovery.” These organizations are already providing care in risk-based models.

What are some of the best practices that payers and providers are using to affect value?

One key to establishing value is the ability to understand a patient population. Dr. Berke recommends providers segment patient populations by the way payment is received as well as health determinants, whether it be through
Medicare, a commercial health plan, Medicaid or another payer.

“Being aware of patients’ health insurance and social context is helpful to attune providers to consider what value may look like for a young adult Medicaid patient, an elderly patient with Medicare Advantage coverage or a middle-aged patient with a high-deductible health plan,” says Dr. Berke.

“Understanding these differences allows providers to better understand social determinants affecting health within those subpopulations,” Dr. Berke says. “With a better understanding of subpopulations, hospitals or practices can apply the right intervention that engages the patient in their care.”

Improving care delivery for a health system’s own self-insured employee population is one way organizations can start to move the needle on value. Most health systems manage healthcare benefit costs for their employees and dependents. A health system’s spend per employee per month tends to be higher than a typical commercial population and can account for a significant portion of a health system’s budget, says Dr. Berke.

“How health systems are incentivized to create value within this population, as they are the ones paying for their employees’ healthcare,” he says. “Within that self-insured segment, health systems can test care management programs that drive healthy behaviors, medical compliance and lower costs. Eventually, they can translate these tactics to other populations,” says Dr. Berke.

For example, a hospital may face difficulty in extending additional wraparound services, such as care coordination, for its chronically ill Medicare fee-for-service patients. However, Medicare has codes that let providers bill for chronic care management services, whether those are provided over the phone or in person.

“Even in this fee-for-service arrangement, physicians can leverage population health strategies,” Dr. Berke says. “They’re building muscle memory in thinking about care beyond the practice or hospital that they can then apply to other populations. High value care means providers must comfortably work with teams and partners, whether internal or external. It includes both the payers and providers. By collaborating and leveraging data and analytics, we can improve the care management process to better understand patient populations and design care plans and interventions accordingly.”

Patients are distinct – Why aren’t we treating them like it?

No two patients are alike. “Ultimately, providers need to flex to a model that is truly patient-centric,” Dr. Berke says.

Value need not be tied to a contract, and it need not be an initiative or program. “Most of what drives value in healthcare are the very same things providers already know to be good medicine. So many of the actions that drive value are already intrinsic to high-performing health systems and care teams. Payers also have the opportunity to become partners with providers and patients to achieve the best outcome,” says Dr. Berke.

It’s this rational, patient-centric approach to value that Dr. Berke believes will carry healthcare forward.

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