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Preparing for a Career

IN VALUE-BASED CARE

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Preparing for the future is essential for any business, and the future of health care, according to many experts, lies in value-based care.

A late 2020 Medical Economics article noted that the Centers for Medicare and Medicaid Services announced plans to

Move
100%
of Medicare providers into two-sided risk arrangements.

And the latest Deloitte Survey of U.S. Physicians predicted a forthcoming shift in the U.S. healthcare model: "Value-based care is no longer something organizations can choose to do as a pilot or an alternative to fee-for-service. Rather, it's a critical part of any health care organization's short- and long-term strategy," wrote the report's authors, Mark J. Bethke, Randolph Gordon, Natasha Elsner, and Hemnabh Varia.

With the shift towards value-based care, healthcare professionals and the medical education system will need to adapt to this new model. While this deviation from traditional practice presents numerous challenges, it provides an opportunity to improve the world of healthcare and better patients' health and wellbeing.

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This paper will discuss:

01 The shortcomings of today's medical education regarding value-based care

02 Changes the medical education system can make to prepare young physicians for value-based care

03 How medical students can learn and practice the principles of value-based care as system-wide changes take shape

How value-based care became a low priority

Today's medical students and residents aren't learning skills or being exposed to environments that prepare them to thrive in value-based care. They're spending the majority, if not all, of their time learning how to operate in the fee-for-service world. Even residency programs, where physicians start and lay the foundation for their career, operate within fee-for-service models and do not prioritize primary care.

Fee-for-service model

Medical schools and residency programs teach and train students in the fee-for-service model because the majority of programs are sponsored by or partnered with hospitals that practice that model. For residency programs in particular, sponsorship is based on downstream revenue for the hospital. Residents see patients in outpatient clinics, then refer patients to specialists, request expensive testing like CT scans and MRIs, or recommend hospital procedures to address their issues. Some of the revenue generated by that additional care is then used to subsidize the outpatient residency program. Then, the cycle begins anew.

"The focus is on generating RVUs (Relative Value Units), first introduced in 1989 by Medicare in an attempt to standardize reimbursement based on the complexity of care, but over time it's been perverted to incent volume of services delivered, rather than health outcomes achieved," wrote Dan McCarter, National Director of Primary Care Advancement, on the ChenMed blog. He cited a 2018 article in the European Heart Journal that showed RVUs don't reflect non-monetizable efforts such as understanding patient values and communicating with family members that can make a difference in care quality. "If we want to prepare tomorrow's physicians to operate in an outcome-driven value-based care health care model, then immersing them day after day in the RVU approach is exactly the wrong way to go," McCarter said.

The lack of primary care exposure

Even if a medical student takes coursework during medical school focused on value-based care, most residency programs operate within fee-for-service models and often do not emphasize primary care. "Outpatient training is often an afterthought, and dysfunctional experiences in the clinic taint trainees' impressions of primary care," noted a STAT News commentary. The lack of positive exposure to primary care is a factor that leads about 80 percent of internal medicine residents – including nearly two-thirds of those who specifically chose primary care tracks – to choose other specialties after their residencies.

> **New doctors don't get a chance to practice what we do, which is relationship-based care, and follow patients for months and years,"** noted ChenMed CEO Christopher Chen.
>
> **"It's simply not possible to do that in a residency environment, at least not today."**

For the residents who do choose to pursue careers in value-based primary care, they have a steep learning curve that value-based care practices must account for. "We can see how inadequate the medical education system is when we hire doctors," Chen continued. "We have to spend nine months putting all new hires – be they straight out of residency or experienced industry hires – through a value-based care fellowship. That's how long it takes to train physicians to be successful (in this environment)."

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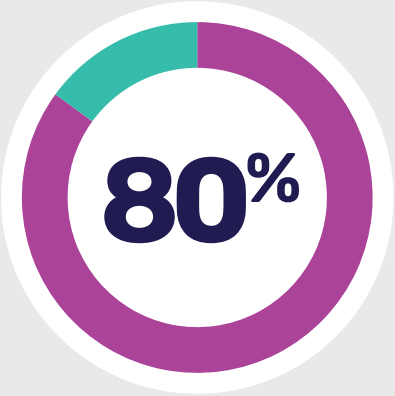

of internal medicine residents – including nearly two-thirds of those who specifically chose primary care tracks – choose other specialties after their residencies.

Medical education for value-based care

It is clear that the traditional medical education system needs to change. Such changes can be achieved via:

01	**Prioritizing prevention and social determinants of health**
02	**Providing hands-on clinical training in value-based care**
03	**Introducing trainees to the business and economics of medicine**
04	**Familiarizing students and residents with metrics and data**

Prioritizing prevention and social determinants of health

"Value-based care requires different competencies and skill sets than what's generally being taught in medical schools today," Schayes said. Currently, most medical schools and residencies emphasize intervention, while value-based care elevates prevention, chronic disease management, and coaching for behavioral changes. Effective value-based care also requires knowledge of and sensitivity to the social determinants of health – all the factors outside of clinical care that have a tremendous impact on whether and how patients can follow a care plan.

If we want residents to think differently, we need instructors to coach them differently," noted ChenMed CEO Christopher Chen.

"For example: Say a resident working in a clinic tells her preceptor a patient isn't taking his heart medication. Instead of doubling down on the instruction, the preceptor might ask: What other barriers are preventing this patient from taking their medication? This exercise encourages the resident to dig deeper."

McCarter echoes this idea, stating that medical students and residents should be guided to work with patients in exploring and integrating different treatments, with an emphasis on the simplest, safest, most effective, and least expensive options. "That means giving medical students and residents one of medicine's most valuable commodities: time with patients," McCarter said.

Providing hands-on clinical training in value-based care

Many of the key tenets of value-based care are at least nominally addressed in medical education, but there's little opportunity for application. The current medical education paradigm provides plenty of hands-on training for specialties like surgery and intensive care, and it needs to provide similar chances for trainees to experience value-based care.

In particular, medical students and residents should have a chance to "develop a relationship over time with a manageable panel of patients," McCarter suggested. Trainees should have a full understanding of the cost of all the individual items that make up a routine visit – especially diagnostic testing – and learn how to weigh those costs against the probability those items will bring about positive patient outcomes.

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Introducing trainees to the business and economics of medicine

Medicine is, at its furthest bottom line, a business. Traditional medical education, however, does not provide much exposure for students and residents to the business aspects of medicine. If and when business is addressed, it's typically a lecture or readings, not hands-on experience. "Understanding the business and economics of medicine requires being immersed in it, even if it's just for a short period of time," Neil said.

To remedy that gap, medical schools can and should offer a rotation focused on the business aspects related to different parts of medicine, including specialty, hospital, outpatient, or value-based care. Schools and residency programs could also arrange short-term shadowing programs with value-based care practices near their campuses. "The schools could make connections to provide these educational opportunities to residents, giving them a window into the real world of medicine," Neil said.

Familiarizing students and residents with metrics and data

Financial success in the value-based care environment means keeping patients healthy and out of the hospital. That requires making students and residents aware of and comfortable with metrics that assess their patients' care. "Do they know how often their patients are going to the hospital after a clinic visit? How often their patients are prescribed medications, but not filling them?" Neil wrote, offering a few examples of the kinds of metrics that correlate with patient outcomes.

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Although students and residents may fear the consequences of poor scores, these data points don't need to be used to punish. Instead, they can indicate areas of strength and weakness. And when they become practicing physicians, **these young physicians can use metrics and data to ensure their patients achieve the best possible health outcomes – and to know when and where to make changes when they're not.**

Alternative healthcare delivery models

Alternative models of health care delivery that medical students – and experienced professionals seeking a change – can consider include direct primary care, concierge medicine, and full-risk value-based care. Read more about the differences between models here.

Direct primary care

With direct primary care, patients pay a monthly or annual fee to providers for regular and enhanced care, such as telemedicine or home-based care. Direct primary care involves smaller patient panels, minimal interaction with insurance companies, and financial stability. However, patients need to carry at least catastrophic insurance for emergency care not covered by a direct primary care provider.

Concierge medicine

In concierge medicine, patients pay a monthly or annual fee to providers for enhanced services and specialty care. Similar to direct primary care, concierge medicine also involves very small patient panels and financial stability. Physicians may also obtain additional revenue from insurance payments, but patients need to carry insurance for physician services.

Full-risk value-based care

With full-risk value-based care, the provider receives a “capitated fee” from an insurer and assumes responsibility for all the patient’s care, including any specialty and hospital care needed. It involves smaller patient panels and flexibility to provide any care necessary. Providers do not need to deal with insurance companies, and it also offers financial stability. Full-risk value-based care is currently used in only a small percentage of practices.