The Harkin Institute
CONNECTING PEOPLE WITH POLICY

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Leveraging Value-Based Care
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The Harkin Institute's mission is to educate, research, and share good policy that works for everyone. Emphasis on the everyone. *Value-based, coordinated care and broader collaborations aim to address a significant and pervasive issue in healthcare, health disparities.* Healthcare should work for everyone, especially the vulnerable populations that are have higher rates of diet and lifestyle related chronic conditions.

Fortunately, over the last two decades the recognition that health is driven by much more than the care received in a hospital or clinic. Health outcomes are driven by an array of factors including genetics, health behaviors, social & economic factors, and of course, health care. We now know that health behaviors, such as smoking, diet, and exercise, along with social and economic factors are the primary drivers of health outcomes.

Understanding this allows us to look at how health and nutrition policy can help solve complex social, economic, and health issues that affect individuals, healthcare systems, communities and society as a whole.

When value-based and coordinated care works, it does amazing things, improving access to broad based care, not just health care, truly making the easier to "make the healthy choice the easy choice".

A key provision of the Affordable Care Act (ACA) is the requirement to cover an array preventive services. The ACA was a game changing piece of legislation. It

shifted the structure of public and private health card towards a value based or an Accountable Care Organization model.

Increasing preventive services is important for a myriad of reasons. One significant reason, it increases access to care. Coverage of preventive services gets patients in the door, improving access to traditional healthcare services.

In addition to preventive screening, screening for social determinants of health (SDOH; e.g., economic stability, neighborhood and physical environment, education, food, community and social context, health care system), which some hospital is doing in Iowa, helps to understand the economic, social, and health needs of a patient leads to the best patient outcomes.

It is then in the best interest of the hospital, clinic, and patient, to support sustainable health outcomes, which as we've established, requires deliberate and coordinated care with partners outside of the health care setting.

For example, the impact of nutrition education and counseling for someone with a diet-related chronic conditions are limited if the patient is food insecure ("limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways") or does not have a home to prepare or store the food they should be eating for their chronic condition.

Going one step further, value-based organizations can and should use federal, state, and local resources to implement innovative strategies for social determinant interventions. Using prescription produce to provide fresh fruits and vegetables to at-risk patients or providing medically tailored meals for patients with diet-related conditions that CAN be treated with medical nutrition therapy.

Collaboration that connect and weave together the services necessary to achieve health equity and prevent chronic conditions are a major part of the solution to sustainable health interventions that will reduce spending and improve outcomes for all patients.

But it's not just about "who" is engaged, but "how" they work together, and "how" progress happens.

Can preventive care play a role in preventing these conditions from developing?

Yes, it has a big role in prevention of chronic disease AND treatment of the same conditions. The current rates of diet-related, preventable chronic conditions are astounding:

- Six in ten Americans live with at least one chronic disease, like heart disease and stroke, cancer, or diabetes.
- The five leading causes of death in the U.S. are heart disease, cancer, chronic lower respiratory disease, stroke, and unintentional injuries.
- Chronic, preventable diseases, such as heart disease, cancer, and diabetes, are responsible **for 7 of every 10 deaths among Americans each year and account for 75% of the nation's health spending**
- In the US, adult life expectancy in the general population has fallen for two consecutive years

Lifestyle interventions are the way to prevent AND treat the biggest burden on our health care system, preventable chronic disease. Preventive services have a huge cost savings, not only in terms of individual health care costs, but the larger societal cost.

In general, estimated savings from well-designed lifestyle programs show that each dollar invested saves more than 3 dollars in medical costs and more than 2.5 dollars in losses from missed work days. In terms of societal cost, the

expansion of access and availability of targeted healthcare innovations that target SDOH are better at addressing health care disparities. Individuals that are more likely to experience disparities in health care are also more likely to be diagnosed with preventable diseases (CITE). A recent analysis estimated that disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year as well as economic losses due to premature deaths. Preventive care also allows providers and partner organizations to focus their time and energy on doing their actual job.

Even though doctors know this and encourage healthful behaviors to help prevent or manage many chronic medical conditions, many patients are inadequately prepared to either start or maintain the prescribed healthy changes. It takes a complete understanding of the different determinants of health and will of the larger system to help someone make the choices necessary to prevent preventable conditions. The truly hard part, and the "value" that value-based and coordinated care should bring to the health care system is lifestyle change and coordinated effort provides the internal and external supports necessary to SUSTAIN individual change.

It makes sense that addressing lifestyle factors and behaviors is a sensible way to prevent people from getting sick and also treat disease.

Now that we're aware of lifestyle implications on overall health, we're seeing big shifts towards addressing policies, systems, and the environment in which we live to improve overall health, which includes physical, mental, social, and economic health.

Policies like the Affordable Care Act increase the availability and affordability of preventive services and screening.

- The ACA was designed to enhance the coverage of preventive services, both for private and public health care coverage. Those covered through the health insurance marketplace must be provided (without charging you

a copayment or coinsurance & even if you haven't met your yearly deductible) with an essential health benefit package that includes preventive and wellness services. **The law also mandates that all private insurance plans and Medicare cover evidence-based preventive services without any cost sharing.**

The expansion of coverage for preventive screening tools helps identify conditions like T2DM.

- Proper diagnosis of the condition leads to referral to preventive interventions, like DPP, with the goal of preventing the onset of diabetes.
- A cost-effectiveness modeling study of DPP showed a 37 percent **reduction in** new-onset diabetes at a **cost savings** of $1.3 billion over 10 years.

Screening for SDOH can also have a huge return on investment. For example, the negative consequences of food insecurity extend far beyond a lack of nutritious food. Food-insecure older adults are more likely to be in fair or poor health, with frequently associated comorbidities including diabetes, depression, hypertension, heart disease, and limitations in activities of daily living. Food insecurity costs the health system an additional $53 billion a year.

Health care systems are slowly but surely making small and large system level change, including integration within and between providers and public partners. For example, UnityPoint Health Berryhill Center, a 2018 Harkin On Wellness designee, is an integrated Community Mental Health Center that offers mental health services to ten counties in Northern Iowa.

UnityPoint Health has implemented a financial assistance policy to allow patients lacking healthcare to still pay a fair and equitable amount based on their ability to pay, if they are able to pay any amount. Patients who cannot afford to pay any amount in payment are still eligible to receive care. Here are a few other examples of the way Berryhikl Center is changing their system wide approach to care:

- They hired a Health and Wellness Coordinator as well as an additional Peer Support Specialist to facilitate classes and further support individuals in their journey toward improved health and wellness.
- They offer smoking cessation, nutrition and exercise education/classes, one-on-one motivational interviewing and trauma informed care.
- They provide care outside of the clinic setting with school-based services and works with community groups like the Fort Dodge Recreation Center to connect individuals with resources.

Berryhill Center is just one example of system change within health care can come from all types of preventive care and innovation.

In Iowa, UnityPoint and other major health care systems hired Community Health Workers to bridge the support between in-patient care and community settings. Combined with comprehensive screening for SDOH AND working collaboratively with community partners, Community Health Workers can seamlessly extend and sustain the care provided in the hospital or clinic.

Innovative and forward thinking programs using medically tailored meals and prescription produce are the way our health care systems should think about the future of care and services. It is possible, and it's happening all over the United States. There are some examples of it in Iowa. At least one FQHC gave a reusable bag full of produce provided by DMARC and sourced from local famers to patients that screened positive for possible mental health conditions.

This is just a start to the many ways that value-based and coordinated care can improve outcomes for all patients and save our health care system trillions of dollars.