Mitigating the unintended consequences of health policy.

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Dr. Jannifer Harper welcomes rural health and legislative affairs expert Bill Finerfrock, and Root Cause Coalition Director Tom Dorney, who previously served as Senior Policy Advisor to Congressman John Lewis. Together they delve into the origins and unintended consequences of new payment models, and how new legislation could mitigate some of the negative impacts these new models have on certain disadvantaged populations who are seeking joint replacement. All views expressed are the participants own.

Dr. Harper: Hello, and welcome to the Health Disparities Podcast a production of Movement Is Life. I'm Dr. Jennifer Harper and I'm a proud member of, The Movement is Life Caucus where I am privileged to work with a wonderful group of individuals and organizations in advancing health equity. And my day job is serving as Chief Clinical Officer with Anthem National Accounts. This will be the first in a series of podcasts exploring the concept of value in healthcare. And we're going to be discussing how value is operationalized in payment models, and how these payment models impact all stakeholders, including the most important stakeholder of all our patients. So, joining me today is a fellow colleague of mine who also serves on the movement is life executive steering committee, Bill Finerfrock. Bill serves as the President of Capital Associates. And prior to becoming president of Capital Associates in January of 2014, he was

Senior Vice President at the firm for more than 20 years. Bill specializes in healthcare financing, health systems reform, health workforce and rural health. Welcome, Bill and thank you for being here.

Bill Finerfrock: Thanks, Dr. Harper, and thanks for the opportunity to participate in the podcast. I think this is an important conversation we're going to have today and one that a lot of people sometimes I don't think understand what we mean when we talk about value in healthcare. So I'm looking forward to talking with you and Thomas today.

Dr. Harper: Thank you again, Bill. Also joining me today, it's my great pleasure to welcome Thomas Dorney. Tom is a director at the Root Cause Coalition, a nonprofit number driven organization comprised of more than 75 leading health systems, hospital associations, foundations, businesses, national and community, nonprofits, health insurers, academic institutions, and policy centers. The Root Cause Coalition works to achieve health equity, through cross sector collaboration in advocacy, education and research. Tom was also for many years, a policy adviser to the late John Lewis, who was a great supporter of The Movement is Life Caucus, and a recipient of our Vanguard Award, and who brought forth significant legislation targeting health disparities during his illustrious lifetime as a statesman, and civil rights leader. So, welcome, Tom to the podcast, we are very, very pleased to have you join us today.

Tom Dorney: Thank you so much, it's really good to be with you, and Congressman Lewis, so appreciated Movement is Life and all the good and great work you're doing to borrow his turn of phrase. And I know he was so grateful for you always keeping your eyes on the prize as he would say, but it's great to be with you today and thank you for having me on.

Dr. Harper: So, let's start by learning a little about the Root Cause Coalition. What is the overall mission of the coalition? And how are you working to achieve that mission?

Tom Dorney: Yeah, thank you for that. So, as you said, Root Cause is member lead, comprised of health equity stakeholders whose primary mission is to end the systemic root causes of health inequities for individuals and communities through cross sector partnerships. We were founded only five years ago as a joint venture between AARP Foundation and ProMedica, which is a health and wellbeing system out in Ohio. The initial focus of the health equity work focused primarily on addressing food and nutrition insecurity, but since then, the focus has broadened to address all types of social determinants of health, housing, or whether they be from systemic racism issues around systemic racism. As you mentioned, our membership is very diverse, and it touches people at different points across the care continuum, but again, we were all focused on the

collaboration and partnerships to develop the kind of innovations to ensure that individuals can achieve their best self.

That's who we are and as to what we're doing. We start from what we think of as our three pillars education, research and advocacy. On the education side, we host a yearly summit on social determinants of health and are always bringing together our members for webinars and supporting working groups to drill down and get to the root causes of the health inequity. We lift up research and are actually going to be releasing some consumer research and general knowledge in the public about health equity and social determinants of health and advocacy is our big focus for the coming year. And certainly, one of the things we're going to be looking at is how to advocate for metrics and new payment models in Medicare and Medicaid to address health inequity, but also ensure payment to care providers and non-clinical community-based organizations for services.

Dr. Harper: Thank you for that Tom. A very, very impressive mission and vision at The Root Cause Coalition. So, I want to return to the subject of value. And I think most of our listeners will have some familiarity with the idea of payment models and terms like fee-for-service and value-based care, but could you share with us how these are in fact very different?

Tom Dorney: Well, fee for service is exactly like what it sounds, then it's probably what most people are familiar with when they think about healthcare. If you have the misfortune of needing some type of treatment or service or medication, the third-party payer, whether that be a private insurer or Medicare, Medicaid, will pay for that service, but it's a very reactive model of healthcare, which is when someone comes in, services are paid for once they're completed. The value-based care is where healthcare providers are incentivized with payments for quality.

Bill Finerfrock: Let me try and tackle the value-based part of this question, because I think it's a really important aspect of the conversations we're going to be having today. You're right, that I think most people are familiar with the concept of value, but how does it actually apply in this context? It's certainly the antithesis of what Thomas described as a fee-for-service system, where the provider gets paid, regardless of whether the service was a value. So take, for example, a patient comes in with knee pain, and the clinician orders an MRI or a CT. Well, was that necessary, was that appropriate, was that of value? Provider is going to get paid by ordering it, but was it really necessary? So, the concept of value says, we're not only going to just pay you for what you do, but we're going to assess it in terms of whether or not that activity actually has value to the patient in terms of making them better, making them healthier, or curing the problem that they came to you with.

Dr. Harper: Thank you for that answer. But I have another question and we've had fee for service healthcare for a very, very long time. So, why have we now moved away from fee for service and toward value-based care models?

Bill Finerfrock: I'll take the first crack at that. I think it's the cost of healthcare, the overall cost of healthcare has grown to such a point in our economy, where it has garnered attention in a way that it has never before. If you look at employers who are paying a significant portion of the healthcare bill, they're finding that it is consuming a greater and greater percentage of their revenues and they're wondering why. Why are we spending so much on healthcare? Individuals are seeing the cost of healthcare whether it's at the provider level, or in the form of health insurance premiums going up and up and up, and so, as it consumes more and more of everyone's dollars, the obvious question they come back with is, am I getting value? What am I getting for this money that I'm paying? And in response to that question, different people who are paying for healthcare and providing healthcare are now being expected to demonstrate that they're providing value to the patient for the money that that they're paying.

Dr. Harper: So, Tom, how would you answer that question the movement away from fee-for-service toward value-based care?

Tom Dorney: I think a fee for service is kind of like the trusty old cars station wagon that's been in your family for years and years, and it's covered in bumper stickers, and you used it to get to the store when you were little and maybe you went to Disneyland. That car is getting really old and even in the times when it seemed to be operating well, it really never got good gas mileage, but most importantly, wasn't really all that safe. So, while we have, as Americans have always understood the importance of prevention, really what we've been doing in the old fee-for-service model is placing an enormous emphasis on treating symptoms and diseases, instead of the root causes of illness and poor health, which led to the creation of more work and spiraling costs that we'll talk about that are out of control.

Dr. Harper: Can you give some examples of value-based care models that are being used today so that our audience can have a better understanding what we mean by value-based care?

Bill Finerfrock: It's a great question. So, bundled payments is probably one of the easier ones to maybe get our hands around. So, as we talked about in fee for service, the provider is paid for each particular service that they deliver. So, it's kind of a piecemeal, ala carte approach to paying for healthcare. A bundled payment is really where they say, all right, the patient has been diagnosed with a particular problem, we're going to pay you an amount of

money to cover all of the care that that patient needs in order to resolve that problem. So, we're going to bundle that all together. The analogy or metaphor I would use is I can go to the grocery store and buy all the items to make a meal, or I can go to the restaurant, and I can have them prepare the meal for me. And I get all the things that are there, the meat, the potatoes, the entrees, whatever. And so, fee-for-service is I'm going to pay for healthcare on an a la carte basis. Bundled payment says we're going to give you the whole meal, and it's up to you to figure out how to how to spend that money for each of the individual parts.

Dr. Harper: It's a great example Bill, I think I'll steal that analogy.

Bill Finerfrock: That’s alright, I'm going to steal Tom's metaphor about the old car.

Dr. Harper: So, Bill and Tom, if you have thoughts on this one, where did these models originate? And from a policy perspective, do these models have bipartisan support? Tom, you supported John Lewis for many, many years, and are very involved in legislative efforts in this area. So, maybe we'll start with you. Do these models have bipartisan support?

Tom Dorney: Yeah, that's a really good question. This is an area that has, surprisingly, always enjoyed bipartisan, I wouldn't say support but interest. The idea of these types of payment models goes way back, they begin, I

believe in the Bush era, and then we're more solidified in statute and in the administration during the Obama Administration, specifically, in 2015, when Congress passed MACRA, Medicare Access and CHIP Reauthorization Act. I will say that my time with Mr. Lewis, I had just the wonderful experience that some people probably have where you are staffing a member of congress when the law is passed, and then you are staffing the same member of congress when you try to fix that law as it starts to become implemented. And today, I think that there is that interest in support remains in Congress. And presently, there's continuing bipartisan work going on in the House and in the Senate and we hope to see in the next Congress in the next administration, the fruits of that, again, healthcare is sort of soloed across geography. And I think that members from different parts of the country have always kind of had their different issues with this type of policy. But, again, I think it's kind of one of those special areas in healthcare that continues to sort of stay above the fray.

Dr. Harper: And Bill, I'd like to hear your perspective as well, particularly with your background and specialization in healthcare, financing and health systems reform.

Bill Finerfrock: Yes, I would say that it actually I think goes back even further than Bush. Thomas is right, that these concepts have enjoyed bipartisan

support. It doesn't necessarily always flow down into bipartisan support for specific policies but the concepts that we're talking about here have had long bipartisan support. I would suggest that it actually goes back even to the 70s and 80s. In the 80s, for example, when we moved hospitals, to diagnosis related group payments, which is essentially a bundled payment, its foundation goes back that far, at least. But one of the things that is a key part of this also that we haven't talked about, and I think it's important to put that into the conversation because I think it ties in with what we'll talk about later, hopefully, when we get to the disparities discussion and that is the concept of shifting risk. And that a key part of many of these value-based components, in addition to trying to incentivize quality is the shifting of financial risk from the payer to the provider. So, that under a fee-for-service example, an individual provider no matter what they do, they're going to get paid for it. Under a bundled payment, if the provider over orders tests or orders things that aren't necessary, there potentially on the financial hook because they're only going to get the bundled payment. And so, we can't have this conversation about value without also injecting in this conversation of shifting risk, and how that may affect decisions on the part of the provider as we move down the road on these Value-Based Payment Initiatives.

Dr. Harper: And we mentioned earlier that patients were the most important stakeholder in this discussion and we talk a lot about patient centered

care. So, one of the most important questions that I'd like to ask, and I'd like to hear from both of you, as how are these payment models intended to improve care for patients?

Bill Finerfrock: I think that, in terms of from the patient's perspective, the way that they're intended to improve, and it gets at this issue I just raised, which is kind of this risk, you want to have a balance here, you want to potentially create some financial risk in the model, but not so much that it discourages providers from delivering care that's necessary. And that's been one of the criticisms of some of the models where you actually disincentivize the delivery of necessary care. From the patient's perspective, the patient doesn't necessarily define value the same as how the provider might define value, in terms of what their expectations are but the message to the provider is, if you don't meet certain quality metrics, if you don't meet certain access metrics, if you don't achieve a certain level of care and we're going to start measuring you and we're going to compare you to other providers, and see how you do, then we're going to penalize you. So, the idea is that you want to inject some incentive, but you want to make sure that the way that they are continuing to deliver care is done in a way that ensures that the patient gets that quality. And so, we've developed all these very detailed metrics to measure quality and built that into the payment model.

Dr. Harper: Tom, what is your perspective on how these payment models are intended to improve care for patients?

Tom Dorney: What Bill said is absolutely right. And I think you know, that, as opposed to the traditional fee for service model, where we're incentivizing volume of services, the shift to understanding and measuring what we're getting for our money, and what the patients are getting, in terms of outcomes, becomes the most important way to calculate think about our healthcare system. I think the problem there is that it quickly gets complicated, because as we all know, in addition to not all providers being the same, not all people are the same, and people are interacting with the healthcare system with a host of different issues, that the doctor may not know about, care about, can't account for and can't address. You know, in my time with Mr. Lewis, as the value models were starting to roll out people were really concerned about the measurement of value. And people would say, well I serve this community, and my patients are dealing with more issues, they're not as healthy or wealthy, and if you start to measure me versus on quality, I'm just not going to compare it to some locations that have healthier and wealthier patients. And so, you need to reward me not just for the quality or the outcome measures, but you need to reward me for process measures and the things that I'm doing for patients. And again, as you can imagine, you start to run the risk of perhaps instituting to different levels of quality, which is discriminatory.

And you know, how are we going to protect against that, and that's kind of the ongoing work to make sure that the healthcare system serves everyone equally.

Dr. Harper: So, it sounds as if the value-based payment models were well intended to improve care outcomes, quality, reduce costs, but despite those goals, we are finding that there may be unintended consequences. And I think Tom, you started to hit on that in your last response. Bill, can you share with our listeners, any additional aspects of value-based models that have become problematic?

Bill Finerfrock: Yeah, and I think Thomas alluded to it, and you just you did as well, which is this idea that the models were designed, there were two principal objectives to the models that when they were designed, they said, well, number one, we want to lower cost, but we don't want to do it at the expense of quality. And so, we developed as we mentioned before, these quality measures to ensure we tried to achieve that balance. What they didn't take into account, and this is something that we spent a lot of time working with Thomas and Congressman Lewis on, which is how does this affect access to care? You know, Thomas made reference to the fact that you know, not every patient is alike. And some patients are more challenging clinically, because of social determinants of health. Other factors that make it much more difficult for them to achieve optimal health

or optimal outcomes. And so if you're going to tell a physician, for example, or a hospital, that you're going to be measured on the patient outcome, which is based on an average patient, or you're going to be measured on readmission rates, or hospital acquired infections for an average patient, but you deal with a patient population that has a significant number of comorbid conditions, has certain social factors that make it much more difficult for them to recover to achieve optimal health, and you're going to penalize that hospital or that provider, using measures over which they have no ability to affect, then the deficiency in the model is that they will over time, start avoiding those higher cost, riskier patients, because it results in them getting a lower quality score. And that's the real danger. That's the missing piece, if you will, of these models is that they only looked at a limited set of factors in determining what constituted value. And the key factor that they overlooked or ignored was this question of access, and how providers would respond to the incentives when they were presented with more challenging patients.

Dr. Harper: What I'm hearing from both of you is that the populations that are most impacted by these unintended consequences are those populations that are experiencing greater healthcare disparities to begin with. You know, this appears to align with the work of Root Cause Coalition, so which populations may be most impacted by these unintended consequences?

Tom Dorney: Let me take a step back and talk a little bit about sort of where Mr. Lewis was, when we were working on this issue together. I can tell you that when MACRA was starting to be implemented, and we were starting to see a lot of momentum around the institution of these payment models, at some point during that period, I remember seeing something on paper from CMS that said that they believe that they wanted to see 50% of all Medicare expenditures coming through these payment models by 2019. It was really ambitious. And at that moment, Mr. Lewis and I sort of looked at each other and it kind of dawned on us that well if we're going to change how hundreds of billions of dollars leaves the Treasury in Medicare reimbursements, somebody's really probably the senior Congressional Black Caucus member on ways and means needs to be needs to be thinking about whether or not changing those incentives are going to exacerbate minority and rural health disparities. And we realized, oh, wait a minute, that's us, we need to do something about it. So, we got to work and I think that the concern for him and us at that time was that for the people who are not as healthy and not as wealthy, whether they be in rural communities or urban communities, we need to protect them and make sure that as these models are implemented, that they are designed in a way that allows the providers who are caring for them the opportunity to thrive and do the work that they're able to do.

Dr. Harper: You've actually started to discuss some of the policy solutions that may be out there. So Bill, maybe you can answer this question as well. How can Value-based Payment Models be improved to address these unintended consequences?

Bill Finerfrock: I think, and I suspect Thomas will agree we both have been involved in Washington policy for a number of years and it's been my experience that there are two types of legislative sins that get that occur, sins of co-mission and sins of omission. The sin of co-mission is something where it was a conscious effort to do something, and then maybe later, we decided that that wasn't the best thing to do, let's fix it. But the more common type of experience is what I refer to as a sin of omission. That in developing a policy, folks sat around a table and said, “Gee, isn't this great, let's look at quality, let's look at cost and let's design a model.” Then, there were two problems. One is in all likelihood, the people that were sitting around that table, developing the policy, probably looked a heck of a lot more like Thomas and I, than they do like you. And so, as a consequence, they didn't necessarily think about the ramifications of the policy and what it was going to do to people of color, people who came from a more disadvantaged background. So, the omission of the policy was that it wasn't designed in a way to take those factors into consideration. And so, as we looked at it, and as we started the conversation with Thomas, several years ago, on behalf of Congressman

Lewis, it was, what can we do to require people to go back and as they are designing these models, as they are thinking about how to do a value-based payment model, that they factor in these issues into the design of the model instead of waiting as we often do. We go out, we test the model, we implement it, and then three years later, we look and go, oh, crap, how did all those people not get healthcare? Well, you didn't design the model in a way that took that into consideration and so the work that Thomas did, said, let's direct the people who are responsible for evaluating these models for helping to design them to tell them, you must look at these things, you must look at what impact the model will have on health disparities. You must look at will it create access problems for individuals based on color, gender, or geography? And so, the idea is to go back and look at how we are designing the model and build it in as a sin of co-mission, rather than trying to fix the model years later, because of a sin of omission.

Dr. Harper: So, what you've described is, it appears that these unintended consequences might have been predictable but during the design, they were not mitigated and none of those issues that may have been predictable were actually addressed. It was particularly concerning to me as a physician because what I'm hearing is that the populations that are already suffering the most from healthcare disparities, this may actually lead to greater disparities, though it was not intended. So, going forward,

do we have a different process in place from a policy perspective, so that in the future, we will be focused on disparities as we create these value-based payment models?

Bill Finerfrock: If God hadn't decided that he needed John Lewis at his side, instead of on this earth, I'd be more optimistic that the future policy development is going to factor these things in. You know, God had a different plan in mind and so we don't have benefit of John Lewis today. But the ideas and the concepts that he was promoting, continue, and it would certainly is my hope, and we have lined up some new individuals who will carry forward the work that was started by Congressman Lewis, in the form of Senator Cory Booker, from New Jersey and Congresswoman Terri Sewell, from Alabama. But Thomas maybe you want to talk a little bit about the congressman's vision and what we can do to help make sure that the vision that he articulated in the Equality of Medicare and Medicaid Treatment Act, becomes a reality sooner rather than later.

Tom Dorney: So, Mr. Lewis and I decided that we really wanted to make sure that these new payment models and Medicare and Medicaid as they were coming into the Innovation Center, were going to be set up in the future so that they can serve the Medicare and Medicaid populations equally, regardless of whether or not they were, how healthy or wealthy they were.

And so, I set out to find stakeholders who had ideas and see who was working in this issue area already, and most of the time when I met with particular groups and the various viewpoints that would find their way up to Mr. Lewis' office, what I would find is maybe a bill or an idea sort of rooted in addressing the social determinants of health, but it was always coming from a perspective that that was born from a preexisting policy agenda. And what we were looking for, though, was a way to, again, as Bill said, tailor these models so that when they're developed, they're thinking about health disparities on the outset.

Bill Finerfrock: Well, it was around that time that you came to the conference that Movement is Life hosted.

Tom Dorney: Yeah. So at that point, that's when I met Bill Finerfrock and the movement in his life caucus. And one of the things that I heard in the conversations with moonlights caucus is the perspective of providers who were saying, again, as Bill said that the implementation of these models means that the risk is going to be shifted squarely back on the providers. And how will providers react to that? That was the deep concern. So, if you're a provider, and you are looking at two different types of patients, maybe one is morbidly obese, or is dealing with other comorbidities, how that patient might fare in whether it be a hip or knee replacement is going to be different than a patient who is much more healthier and wealthier.

And that provider will then be on the hook for a payment that is based in quality where the provider may try to steer clear of a patient who is not as healthy or wealthy.

Dr. Harper: So, a few terms we've heard being tossed around when we talk about value-based care and unintended consequences. I've heard about lemon dropping, and cherry picking. So, can you explain to our audience what those terms mean?

Bill Finerfrock: I'll take a crack at it and then, Thomas, if you want to add anything, but cherry picking is that situation where the provider seeks out those patients whose costs are going to be below the norm and on whom, therefore they have a good potential for not being penalized and in fact, potentially, making a profit on the patient. So, if you took two patients, Thomas was alluding to this. Let's say you're an orthopedic surgeon, and you have two patients who come in with knee pain. One is suburban, 45-year-old mom, whose kids are away at college who plays tennis three days a week, who's in pretty good shape, nonsmoker, but is having knee pain and is probably in need of knee surgery. You have another patient who's the same age but is overweight, smokes, lives in an apartment building that has four floors with no elevator has three children who are living at home. She is a single mom and has little in the way of a support system and is in knee pain and in likelihood of needing knee surgery.

Cherry picking says the provider is going to encourage that 40-year-old/45-year-old suburban tennis mom, we're going to do knee surgery, because we're going to be able to do that, get you in, get you out, get you home, get you doing the rehab, maybe a little bit of home health, and you're good to go. For the other patient, the provider is going to lemon drop and avoid that patient. Yeah, you think about the literally the concept, you put a lemon drop, you kind of get that little headshake of I'm not sure if I like that reaction to the patient. And say, you're probably not a very good candidate for knee surgery, we'll try some rehab, I'll give you some medication, take some ibuprofen, go home, maybe lose some weight, and then we'll look at it again because that second patient is much more likely to have to be, spend some time in the hospital, much greater likelihood that there could be the potential for rehospitalization because of poor outcomes. The rehab may not go well they're in an apartment building, as I said without any elevator. So, the provider is going to try and avoid or lemon drop. Why? Because they are incentivized, they're getting a bundled payment. That says you're going to get only so much money regardless of which pace and so I have a patient that it's going to take two days, another one that's going to take longer. One's going to probably actually be hospitalized and one maybe I can do as an outpatient. And my financial incentives are such that I have been attracted, I want to cherry pick, select that low cost, very likely high outcome patient and I'm going to

avoid that high-cost patient with a high likelihood of poor outcome because I don't want to be penalized.

Dr. Harper: That's a little disconcerting, though and as a concept, I certainly understand but have we seen this happen in real life?

Bill Finerfrock: Yes, unfortunately, we see examples of this type of response in different circumstances. One of our colleagues tells the story about some research that was done a few years ago where it was a secret shopper experience, where male and female patients, in this case, it was looking at the responsive and provider based on all the clinical, all the insurance, information, etc. The responses to the questions were the same for a male patient and a female patient level of pain, level of discomfort, level of activity. And what they found was that the orthopedic surgeon in this case was looking at, I believe, knee pain was 20 times more likely to recommend surgery for the male patient compared to the female patient. And when they did the follow up, the reasoning was that they felt that women tended to exaggerate the level of pain. So, even though, both may have said if the doctor said on a scale of 1 to 10, with 10, being the most extreme level of pain and one being, I'm fine, what's your level of pain? All the responses were seven but the reaction on the part of the doctor was, well, the male is probably in more pain than a seven, but because he's a man, he's probably suppressing it and so, his seven is really an eight and

a half. And they also said that, while the woman seven probably wasn't a seven, because she's exaggerating, so it's probably only a five and a half. So, we'll recommend surgery for the man because they're in more pain and will recommend some medication and some stuff for the woman, because she's not. And it's that kind of implicit bias, that we see that can show up here in these kinds of situations where now you've not only got an implicit bias, but you've also got a financial component to it, which is only going to exacerbate that inherent bias that might already exist.

Dr. Harper: I guess this is a real life situation and is occurring today and impacting our patients adversely. I'd like to spend the next few moments talking about value from the patient's perspective. Movement is Life champions equitable healthcare, and one of our approaches is to give a voice to patients who are representative of the populations that are most impacted by health disparities. After all, we've said the patient is the most important stakeholder. So, we've actually convened a series of focus groups to discuss some of the issues that we've talked about today and to get feedback from patients in particular and how they define value. One of the key findings of these focus groups is that there is a significant and problematic disconnect between what patients consider valuable and how value is defined in our healthcare systems. And very interestingly, the focus groups consistently stated that what's most valuable to them as patients is clear communication, and being treated with respect. So, one

of the questions I'd like to ask of both of you is this disconnect, perhaps a major barrier to patient centered and equitable care.

Tom Dorney: Thank you for that question. And let me take another step back by saying, I think when Mr. Lewis was developing the Equality in Medicare and Medicaid Treatment Act sort of inherent in that was this internal timeline, internal clock that we all had about we were going to change the incentives in Medicare and to really address minority and rural health disparities. And the intentions were good, and the mission was clear. I think that what happened, though, was when COVID hit our shores, I remember, we were actually on the cusp of reintroducing that legislation again, and it just became clear to us that we were too late, and for all of the people that Mr. Lewis had been concerned about, making sure that the disparities and the social determinants of health that they were dealing with were addressed that we that we had missed that window of opportunity to protect them. And so, now in the era of COVID, like before going to really do community health without a vaccine at this point, at that time there was no vaccine, so we were thinking without a vaccine without a really, effective treatment or cure, the only tools we have are public health tools. And so, if you want to do community health, you need to bring in the community and those voices about what is important to them. Is it economic stability? Is it food insecurity? Is it transportation? Like

those things need to be addressed and those things need to be at the forefront, or I think, we'll again, miss the mark.

Bill Finerfrock: I mean, I think this is a key part of the conversation and it gets at one of the issues of who's defining value? Is it the patient? Is it the provider? Is it the insurance company? Is it the employer? And each one of those has a value proposition that they're going to define value differently. And as you pointed out, the patients have certain aspects of value that has been teased out by these focus groups, and the kinds of things that they look at from a value proposition, are not necessarily what the government or a third-party payer might define as value. So, that disconnect, we have to try and figure out how to get everyone on the same page, because we can all embrace the concept of value and somebody says what do you think of value-based care? And you ask 10 people, “What do you think of value-based care,” and all 10 people say, “I support value-based care.” But each one of those people is going to have a different definition of what constitutes value. So, it was kind of like what we were talking about earlier, we've got this broad buy-in to the concept of value-based care but what each of us means when it gets down to how to operationalize that is different. And so, what Movement is Life and what Root Cause are trying to get at is this idea that there is a component of value here at that patient level, that isn't part of the conversation because the people who are defining these things are people who sit in the

boardrooms of insurance companies, who sit in the offices at the centers for Medicare and Medicaid services. You know, the people who sit elsewhere, and it's not the people who are at the dinner table, who are having their concept and their vision of value that's part of the conversation, and that's what I think Congressman Lewis was trying to get at and has for his career. His career was to say, worry about the people, worry about the patients, where is their voice in this conversation?

Dr. Harper: So, the findings from these focus groups have been captured in a publication called, "*Values Defined by Whom"*? This is a Movement is Life publication, and we will make this available to our listeners. The publication also includes a helpful analysis of the value-based care concept and elaborates on unintended consequences that we've discussed today. So, I think there's a general consensus that there is a disconnect, in how patients define value and how other stakeholders define value. Tom, could you share, perhaps how the Root Cause Coalition is addressing the need for better communication and treating patients with respect?

Tom Dorney: Last year, the Root Cause Coalition released our status of health equity report for 2020 and part of that included an eight-point call to action by 2025, and in the era of COVID for 2021, we decided we needed to focus down on maybe four areas that would be the best use of our energy

and time and should really be the focus. One of those for us is going to be advocating for policies to improve cultural competence in the healthcare workforce and also advocating for policies that address specific health disparities stemming from systemic racism, but also maternal and infant mortality and mental health. So, I think included in that would be the Equality of Medicare and Medicaid Treatment Act and ensuring payment for non-clinical services. So, a strong advocacy agenda, but also lifting up the work that our members are doing and bringing people together to share best practices and strategies to affect some change.

Dr. Harper: So, Bill, and Tom, I want to thank you for joining us today and thank you all for what you are doing in continuing to advance health equity. And in closing, I'd like to thank our listeners for joining us today. If you would like to download the publication mentioned earlier, "*Values Defined by Whom*", please go to this podcast on our website at www.movementislifecaucus.com where you will also find a link to the transcript of this discussion. Stay safe, be well and goodbye for now.

(End of recording)