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Value-Based Payment Reform Part II
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Your Life Y our Health
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Team Approach to Healthcare Delivery

The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. In fact, that is the imperative of Medical Home. Without an active team with team-consciousness and team-collegiality, Medical Home is just a name which is imposed upon the current means of caring for the needs of others. And, as we have seen in the past, the lack of a team approach at every level and in every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

Why is this? Typically, it is because healthcare providers in one discipline are trained in isolation from healthcare providers of a different discipline. Or, they are in the same buildings and often are seeing the same patients but they rarely interact. Even their medical record documentation is often done in compartmentalized paper records, which are rarely reviewed by anyone but members of their own discipline. This is where the first benefit of technology can help resolve some of this dysfunction. Electronic health records (EHR), or electronic medical records (EMR) help because everyone uses a common data base which is being built by every other member of the team regardless of discipline. While the use of EMR is not universal in academic medical centers, the growth of its use will enable the design and function of records to be more interactive between the various schools of the academic center.

And, why is that important? Principally, because more and more healthcare professionals are discovering that while their training often isolates them from other healthcare professionals, the science of their disciplines is crying for integration and communication. For instance, there was a time when physicians rarely gave much attention to the dental care of their patients, unless they had the most egregious deterioration of teeth. Today, however, in a growing number of clinical situations, such as the care of diabetes, physicians are inquiring as to whether the patient is receiving routine dental care as evidence-based medicine is indicating that the control of disease and the well-being of patients with diabetes is improved by routine dental care. Also, as the science of medicine is proving that more and more heart disease may have an infectious component, or even causation, the avoidance of gingivitis and periodontal disease have become of concern to physicians as well as dentist.

The SETMA Model of Care

1. The tracking by each provider on each patient of the provider's performance on preventive care, screening care and quality standards for acute and chronic care. SETMA"s design is such that tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the personal provider, nurse, clerk, management, etc.
2. The auditing of performance on the same standards either of the entire practice, of each individual clinic, and of each provider on a population, or of a panel of patients. SETMA believes that this is the piece missing from most healthcare programs.
3. The statistical analyzing of the above audit-performance in order to measure improvement by practice, by clinic or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, payer class, socio-economic groupings, education, frequency of visit, frequency of testing, etc. This allows SETMA to look for leverage points through which SETMA can improve the care we provide.
4. The public reporting by provider of performance on hundreds of quality measures. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease management tool "plans of care" and the medical-home-coordination document summarizes a patient's state of care and encourages them to ask their provider for any preventive or screening care which has not been provided. Any such services which are not completed are clearly identified for the patient. We believe this is the best way to overcome provider and patient "treatment inertia."
5. The design of Quality Assessment and Permanence Improvement (QAPI) Initiatives - this year SETMA"s initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital. We have completed a Business Intelligence (BI) Report which allows us to analyze our hospital care carefully.

Essentials of Value-Based Payment Reform

From our philosophical foundation above we have identified the following elements of payment reform which are:

1. **Capitation** – 50% of the expected reimbursement under value-based payment reform should be received by a practice as a fixed payment which is distributed monthly. This is a forced economy of care as only one payment is made each month no matter how often the patient is seen.
2. **Patient-Centered Care** – this includes patient activation, patient engagement and shared decision making with a personalized plan of care and treatment plan. The achievement of recognition and are accreditation for Patient-Centered Medical Home, when associated with other evidences of coordinated care should be an independent variable for enhanced, value-based payment. The highest credit for this element of value-based payment should be gained by having both NCQA Tier III PC-MH Recognition and one other of the accrediting agencies certificates (URAC, AAAHC, and The Joint Commission).
3. **Evidenced-Based Performance Metrics** – this includes a standard set of NQF, PCPI or NCQA quality metrics which are fulfilled incidental to excellent care and not as the intention of care.

To these, we add the following concepts:

4. **Hierarchical Code Categories (HCC) and RxHCC** – this designation attempts to balance the complexity of diagnoses in order to reward providers for caring for patients with more complex illnesses which cost more to care for. This system should be used to balance both the capitation payment and other payments made in the value-based payment system.
5. **Preventive Healthcare** – as improved preventive care is one of the foundations of hope for controlling escalating healthcare costs, excellence in evidenced-based preventive care should be used in making value-based payment decisions.
6. **Screening Healthcare** – as early detection mitigates the costliness of chronic disease particularly in cancer treatment; excellence in screening care should be used in making value-based payment decisions.
7. **Benchmarking** – value-based payment must include the contrasting of high-performing practices with other practices in rewarding those who perform excellently as judged by comparison with evidenced-based standards and performance standards.
8. **Coordination of Care** – efficiency of care, coordination of care and consistency of care contribute to the management of the cost of care and thus should be calculated in value-based reimbursement.
9. **Transitions of Care** – the use of effective tools of transitions of care enhancing the continuity of care with improved patient safety and care quality should be measured and rewarded.
10. **Patient Communication** – provider/patient communication through secure texting, patient portal or other electronic means should be a part of value-based payment reform.
11. **Patient Experience Reporting** – as one of the elements of the Institute of Healthcare Improvement's Triple Aim and as a proved element of efficiency and economy of care, the measurement of patient experience should be a part of the calculus of value-based payment reform.
12. **Global Cost of Care** – as providers drive down the cost of care while maintaining the quality of that care, they should be rewarded.
13. **The Power of Electronics** – innovative and creative uses of the power of electronics to improve healthcare with electronic patient management, including the use of clinical decision support, disease management tools and electronic measurements of risk should be rewarded.
14. **Risk Stratification** – the calculation and the sharing with patients of their cardiovascular, cerebrovascular and other disease risk scores with plans of care for mitigating those risks should be a part of the payment reform.
15. **Behavior and Mental Health** – the integration of behavior health into the medical home should contribute to payment reform. The use of depression, stress, and wellness questionnaires should be included in this element of payment reform.
16. **Weight, Exercise and Smoking Counseling** – basic to all health improvement the ability to and the practice of evaluation and intervention in these areas should be a part of value-based payment reform.

Other essentials and/or elements of value-based payment reform will be identified but these begin the process.