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FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 5: SUCCESSFUL POPULATION HEALTH MANAGEMENT - INSTALLMENT 2

This article is part of a series about value-based payments and their applications in the healthcare landscape. This is the seventh article in the series and Part 2 of a two-part installment on population health management

Introduction

Providers have been straddling a line between fee-for-service (FFS) and value-based payments (VBP) at varying levels for some time now. After decades of FFS, providers need time to adjust to new climates and systems of incentives. These factors make progress slow and also challenging for the systems brave enough to venture into new territory. At its core, VBP aims to align the quality of care delivered to the payment model. The emphasis on value and quality put the care of the patient in a new and unique place. Not only do their outcomes mean success clinically, but help to ensure financial success in value-based payment arrangements.

Previous articles in this series have examined the foundation of new payment models, including structure and characteristics of unique VBP arrangements, expectations around provider readiness, construction of high-performing networks, and critical business functions for successfully managing a defined population under VBP arrangements. Installment 2 of this two-part article includes a deeper look at how patients stand to benefit from these new payment models.

Putting the Patient at the Center

It is one thing to put the patient at the center of care delivery. Placing them at the center of how a system is paid is uncharted territory for many in this industry – especially when the system of care is paid under a VBP model. As successful population health management programs anchor their delivery and payment arrangements around the patient, the healthcare industry has seen endless models and different options for how patients should be positioned at the center of these complex ecosystems. While designing the perfect care model is nearly impossible, integrated healthcare systems with mature population health management programs can utilize intelligent and empowered clinical governance to guide the appropriate characteristics of care delivery that can be expected to work in new VBP arrangements. Different levels of experimentation will be involved, and the health systems that are willing to take the risk and test these different models stand to gain financially and become models for others to follow suit.

Operationalizing patient-centered care models nearly always begins in the primary care setting, but that's not a rule set in stone. Data systems allow for identification of where care models should be incubated and tested. Recommending these to clinical governance helps to ensure all stakeholders are involved in the evolution of the organization as it transitions to VBP. Successful examples of this work currently exist in specialty-based care models because they empower specialists to manage quality (e.g., service line co-management). In these kinds of models, surgical specialists partner in coordinated ways with primary care providers to understand clinical appropriateness for surgical intervention and agree on implementation of evidence-based guidelines for delivering clinical care to patients in both primary care and specialty settings. These kinds of patient-centered models allow for both the patient and provider to perform their respective roles in delivery and payment for healthcare services. Another area of success emerges when connections between primary care and behavioral/mental health materialize and providers find alignment with increased collaboration - a model that not only encourages collaboration

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for improved patient care, but also hinges on it financially. Development of integrated physical and behavioral healthcare delivery models helps to ensure patients with any additional behavioral /mental health needs are cared for, may help manage the overall cost of care, and may benefit the entire support network for the patient.

Try, Test and Try Again
Regardless of the specific payment mechanism, having a willingness to iterate, test, fail, and try again is critical to long-term success of any organization during transition from volume to value. Not only is it expected that systems developing new programs will undergo a variety of iterations before landing on one that suits the needs of their particular organization, it should be wholly accepted by leadership that failing and testing are just part of the journey.

Effective and sincere communication and dialogue are critical for meaningful group learning. Clinicians and other stakeholders, possibly even patients and caregivers when appropriate, should all have a voice in shaping the care model and contributing to each iteration. Having a channel of feedback will help to ensure that each version of the model has input from all the parties affected by the change. When programs are developed in this collaborative way and projects are course-corrected early on, it protects against obvious structural issues that may be overlooked and could have been easily avoided.

Why VBP Matters for Patients
New payment models stand to shift the paradigm of care delivery in the U.S., particularly in the minds of patients. Increasing costs for healthcare coupled with limited understanding of the complex payment environment have resulted in skepticism among the general public with regard to unnecessary and superfluous testing and service delivery. It is important that the tainted view of fee-for-service be rectified in favor of a nurturing doctor-patient relationship centered on care and compassion.

Removing the link from volume and dollars nudges the relationship away from previously held beliefs and decreases the sentiment of unnecessary care. While healthcare systems must be cautious in how far the pendulum swings, careful not to evoke the same criticism from the days of HMOs and traditional capitation, VBP brings new priorities to the cost equation that can support reinstatement of trust in the doctor-patient relationship.

Conclusion
Overall, as a system, there are many ways patients will benefit from the shift away from volume driven payments. These new VBP models, involving providers taking on more individual responsibility for the health of their patients, will require attention, infrastructure, and a shift in perspectives. While these may seem as further contributing to the complexity and uncertainty patients feel in accessing care or understanding how the system functions, successful versions of VBP create a host of positive externalities that come from putting the patient's health, financially, at the center of the economic equation.

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