

Value-Based Care

Promote the Triple Aim

Developed in partnership with



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How will this module help me adopt a value-based care model?

- 1 Details five STEPS to prepare your practice for value-based health care.
- 2 Answers common questions about becoming a value-focused organization.
- 3 Provides case reports describing how physicians can create value-based practices.



Introduction

What is value-based care?

Unlike traditional “fee-for-service” care models that link payment to the number and type of services utilized, “value-based healthcare is a health care delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.”¹

Five STEPS to prepare your practice for value-based care:

1. Identify your patient population and opportunity.
2. Design the care model.
3. Partner for success.
4. Drive appropriate utilization.
5. Quantify impact and continuously improve.

1

Identify your patient population and opportunity.

Knowing your patients is the foundation of value-based care. Patient populations with the highest risk of hospitalization or high utilization of the emergency department (ED) tend to drive high health care costs and most often receive fragmented care. These populations often include poly-chronic patients — those with chronic and complex conditions with multiple co-morbidities, such as diabetes, hypertension, depression, heart failure, cancer, kidney failure, or chronic obstructive pulmonary disease.

Understanding which patients drive your highest cost of care and those who use the ED frequently will help you to identify your target population and opportunities for improvement. Once you have this information, you can begin to develop your model.



I have seen patients go from disengaged to self-motivated, from helpless to hopeful, from naïve to empowered by education and knowledge. This clinic has not only saved lives but has changed lives as well. The positive impact has a ripple effect, where we are not only impacting their heart failure but their overall health.



Q&A

Are there other considerations I should make when evaluating opportunities to implement value-based care?

Yes. Patients in the practice whose conditions are not adequately controlled are more likely to cost your practice through no-shows, are less likely to adhere to their medications, and may call more frequently for medication refills than patients whose conditions are well managed. Downstream effects to consider beyond ED and hospitalization include costs for medications, home health care, durable medical equipment (DME), and skilled nursing facilities.

What goals should be pursued as part of an alternative payment model (APM)?

The American Medical Association (AMA) recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs). As such, the AMA supports that the following goals should be pursued as part of an APM²:

1. Be designed by physicians or with significant input and involvement by physicians;
2. Provide flexibility to physicians to deliver the care their patients need;
3. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
4. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
5. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
6. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
7. Avoid placing physician practices at substantial financial risk;
8. Minimize administrative burdens on physician practices; and
9. Be feasible for physicians in every specialty and for practices of every size to participate in.

Are there guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members?

Yes. The AMA recommends that the following guidelines are considered²:

1. Identify leading health conditions or procedures in a practice;
2. Identify barriers in the current payment system;
3. Identify potential solutions to reduce spending through improved care;
4. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
5. Define services to be covered under an APM;
6. Identify measures of the aspects of utilization and spending that physicians can control;
7. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
8. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
9. Identify mechanisms for ensuring adequacy of payment; and
10. Seek support from other physicians, physician groups, and patients.

Can CMS or private payers provide support to implement successful APMs?

Yes. CMS and private payers can support the following types of technical assistance for physician practices that are working to implement successful APMs²:

1. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
2. Assistance in obtaining the data and analysis needed to monitor and improve performance;
3. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
4. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
5. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.

Does my patient's insurance plan matter?

A patient's insurance plan does not influence the quality of care patients receive; however, the insurance plan does impact -the services and benefits that can be offered to the patient in order to keep his or her out-of-pocket expenses to a minimum. Moreover, many insurance plans are incorporating Value-Based Insurance Design (VBID), through which patients' cost-sharing can vary to encourage use of high-value care or discourage use of low-value care. This is an opportunity to align goals of value-based payment with clinical and financial incentives for patients.^{3 R4 R5}



2 Design the care model.

Develop care models that are evidence-based and easy to follow.

You can consider the following elements in the development of your value-based care model:

- Identify the target patient population(s).
- Identify which payers will be involved.
- Estimate how the type and volume of services will change. Involve your legal advisors at the outset so you are aware of and design the program in compliance with federal and state laws.
- Identify the benefits expected for patients and payers.
- Design the workflows required to provide the desired care to the selected patient population.
- Discuss details including:
 - Team members who will support the new model.
 - Roles and responsibilities of each physician and the care team.
 - Frequency of patient contact (via phone call, email, or portal messaging).
 - Frequency of patient visits to the practice or from home health care.
- Identify measurable success metrics for each population, and determine your baseline in order to quantify your impact in the future. Your metrics should be easy to capture in the electronic health record (EHR) or population health registry to prevent having to extract them manually.
- Identify transition costs (as a note, revenue needs to be addressed as well as risk-stratification).

Depending on the licensure, education, and training of your team, current team members could potentially fill the staffing needs of the new value-based care model with proper education and redistribution of responsibilities.⁶ Utilizing current staff can be cost effective during the initial transition period, but additional staff may be needed as the model continues to be adopted by the practice, particularly since value-based models rely heavily on effective care coordination and require a greater amount of data capture and analytics.

The care team should be led by a physician⁷ to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.⁸

Roles of other team members who care for patients in the model could include:**Patient outreach coordinators.**

Non-clinical team members who can utilize patient registries and analytic tools to reach out to patients who need additional assistance from a variety of care team members.

Nurse educators/navigators.

Registered nurses with specialized training in [appreciative inquiry](#), motivational interviewing, [health coaching](#), and case management can positively impact the health of patients by extending the traditional reach of providers and their clinical care teams. They can intervene with the most vulnerable populations between office visits to educate and assist them in better managing their chronic health conditions. Registered nurses can schedule appointments and cover patient education, as well as provide the hands-on support and partnership that patients need to improve their health.

Care coordinators.

Medical assistants (MAs) with training in population health management, clinical documentation, and quality improvement can work closely with the nurse navigators to provide follow-up communication and care coordination for high-risk patients. MAs can routinely check in with patients to support adoption of healthy behavior changes and work independently or with patient outreach coordinators to identify and close care gaps through patient engagement.

Certified medical assistants (MAs).

Certified MAs (CMAs) can perform medical record reviews for patients scheduled for upcoming clinic visits, coordinate daily huddles, obtain all pertinent vitals and labs, complete medication reconciliation, and set the visit agenda with the patient, in accordance with state law. In this more advanced MA role, the CMA has the opportunity to start identifying gaps in care in preparation for the physician visit and then [document the visit](#) while in the room with the physician. After the physician finishes the encounter, the CMA makes sure the patient understands the plan of care and answers any questions. This type of workflow allows the provider to focus more on the patient and ensure that all the patient's needs are met during a single office visit, thereby increasing provider productivity and quality, while reducing clerical burden. While working within his or her scope of practice, the CMA is able to answer patient questions and coordinate patient care after the visit, providing continuity and consistency for patients.

Referral coordinators.

Employees responsible for both scheduling referrals and obtaining any precertification required by the patient's insurance company are referral coordinators. Referral coordinators also communicate with the patient to confirm that the next appointment is kept. Referral results are obtained by the referral coordinator and scanned into the patient's medical record or sent electronically for the physician to review, if needed. If any follow-up care is needed, the coordinator can connect with the patient and schedule the proper appointment. Referral coordinators must be mindful of applicable federal and state laws including those that prevent patient steering and protect patient choice.

Transition of care nurses.

Nurses can provide support and care coordination services to patients undergoing a transition between different levels or venues of care. This function requires meticulous attention to the details of a patient's care, including, but not limited to: medication reconciliation, discharge instructions, resource availability for outpatient or community-based care, and provider follow-up within a defined time frame. In your practice, these nurses could make sure that patients who are seen in the hospital or ED receive the follow-up care they need in the practice by scheduling those appointments.

Extensivists and hospitalists.

The extensivist team works alongside the hospitalists, ensuring that patients receive the appropriate follow-up care and care coordination after they are discharged. Hospitalists and extensivists work hand-in-hand with care transition teams to ensure that proper follow-up care is received and understood by the patient and care team.

Some practices also use nurse practitioners, care managers, and others to assist with care transitions and patient care management. Again, referrals must be handled in accordance with federal and state law requirements.

Q&A

What is the best staffing model for implementing a value-based care model?

The best staffing model is one tailored to your patients' needs and your practice's goals. The practice should anticipate how many patients will benefit from the model, and build the appropriate team to effectively achieve the chosen metrics.

While every staffing model looks different, every health care team should be led by a physician, and the AMA recommends that you consider the following elements when planning a team-based care model⁸:

- Patient-centeredness
- Teamwork
- Clinical Roles and Responsibilities
- Practice Management

More details about guidelines for developing physician-led health care teams can be found [here](#).

For example, one group practice found that a single health navigator could effectively address the needs of 250 patients at a time, even for populations with many patients with poly-chronic and complex conditions. This ratio may or may not be appropriate based on the health status of the patients within your population. Continuous reevaluation of the staffing model is necessary to ensure the needs of your patients are being met, unnecessary costs are being prevented, and a sustainable future is ensured.

Can we combine several functions into one position?

Yes, as long as the functions being performed are consistent with the scope of practice, education, and training of a given team member. In many organizations one team member functions in multiple roles. For example, a receptionist may also be the patient outreach coordinator, helping to close care gaps using the panel management tool. Some organizations have found that a high functioning nurse may do the work of a navigator, care coordinator, referral coordinator, and transitions manager. Additionally, the nurse can also assist with in-person visits, and improve the nurse's patient-provider relationship through care coordination, which also helps eliminate the extra work of hand-offs between multiple roles.

What metric- and goal-setting resources can I use?

The PCPI[®], the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set[®] (HEDIS[®]), and CMS identify nationally recognized quality metrics and goals each year that you can use for your quality metrics. You can select the metrics that are most relevant for your patient population and can be easily measured in your practice. You can also work with your patients' insurers to identify which goals and metrics are chosen for their value-based plans.



3

Partner for success

Depending on the size of your practice or organization, you may need the additional resources that a collaboration can offer to help you successfully shift to a value-based care model. Coordination with local hospitals, practices, urgent care centers, insurers, or other organizations may enhance your ability to offer better transitional care and outpatient care management to your patients. Multi-provider arrangements should be considered with legal advisors to avoid running afoul of fraud and abuse and other laws applicable to the health care space.

Care fragmentation poses a major safety risk and can lead to patient dissatisfaction and disengagement. The hospital-practice collaboration is a great example of an opportunity to decrease care fragmentation through coordination and communication. A hospital collaborator may be able to provide discharge lists and ED visit reports that can help your practice follow up with patients and ensure continuity of care.

Table 1.
Tips for negotiating with potential collaborators
 Suggestions to ease negotiations with payers and partners

Do	Don't
Review your practice's historical performance before starting negotiations with a specific payer or partner	Allow too much time to pass between negotiation meetings
Identify internal "must have" goals and rank them in order of importance	Be passive in the negotiations
Evaluate multiple payers and partners	Be adversarial
Be proactive and prepared	
Be collaborative	

Q&A

How can collaborating with other organizations help me improve patient care?

If you do not have privileges at a hospital, collaborating with a hospital could allow you access to your patients and their records when they are seen in the ED or admitted into the hospital. This also provides you with the opportunity to participate in transitional care planning. Such arrangements may help reduce inpatient admissions, ED visits, duplication of services, and drive coordination of care.

Collaborating with home health agencies, skilled nursing facilities, pharmacies, and other community resources can also help providers communicate and work together across the continuum of care. You may also consider collaborating with an independent practice association (IPA) for the potential benefit of

resource sharing. Provider collaborations and referral arrangements implicate federal and state law that require legal counsel advisement.

How do I approach a potential collaborator about helping us deliver value-based health services?

Even though some practices have been using value-based health care models for several years, fee-for-service models still make up more than one-third of all reimbursements.⁹ Begin conversations with potential collaborators and payers by asking them to help you and the community make this move toward value together, for the well-being of your patients. Come to the table with a thoughtful business model that you can discuss and involve your legal advisors.

Why should I consider payers as collaborators? Which payers reimburse for value?

Aligning with payers who reward positive outcomes could result in additional financial compensation for your practice, and an opportunity to help shape insurance design for your patients. Collaborating with payers can be a chance to align your clinical goals for your patients with insurance cost-sharing rules that encourage your patients to pursue high-value care.^{3 R5 R9} While not all value-based approaches result in cost savings, especially at the outset, the parties can agree to modify the model as they learn. Be mindful of where any cost savings are redirected – to external partners (such as hospitals or other entities), payers, or physicians, or a blend. You should have an independent legal counsel review any contracts you are considering. Also, be aware that for some practices, cost savings may not be achieved for several years.

Some payers will have pre-determined quality measures that you must meet prior to receiving financial compensation, and you can build these into your value-based care model. Ideally, payer contracts should be negotiated so that the metrics or measures are beneficial to both parties involved, as well as patients who will be served.⁹ It is important to negotiate payments and penalties prior to signing contracts with each payer to ensure the metrics selected are ones that your practice can track and achieve.

“

By partnering and establishing trusting relationships with patients, caregivers, providers and community partners, [we] are able to improve quality of life, satisfaction with care, and reduce unnecessary spending.

”

Edgar Maldonado, MD, Cornerstone Personalized Life Care Clinic, High Point, NC



4

Drive appropriate utilization

As the new model is adopted, look for ways to reduce unnecessary costs or variances, and drive utilization toward a lower-cost, highest-quality approach. Often, when patients stay within an integrated provider network, it enhances quality and reduces cost. However, patient choice and clinical needs ultimately govern where a patient receives care.

As your team is increasingly empowered to help your patients manage and improve their chronic or poly-chronic conditions, collaborators may increasingly rely on your practice as the new model is adopted and refined. Through a more effective, [team-based approach](#) to care, outcomes should improve, and physician time can be spent on new appointments, annual visits, and critical patients. Intermediate care, follow-ups, and education can be provided by other members of the team if deemed appropriate by the physician team leader, and/or in accordance with each physician's practice preferences.

By working with your practice's financial expert or using analytic software to determine your high-cost spending patterns you can identify if there are any unnecessary costs associated with your practice. Note that there may be some start-up costs associated with purchasing these programs.

For instance, analysis may reveal that an imaging center used by your practice is more expensive than others in the area. After comparing the quality of services and ensuring value, it may be prudent to start referring patients to high-quality, lower cost centers. Discuss referral practices or proposed changes with legal counsel to ensure compliance with applicable federal and state laws.

Other STEPS Forward™ modules may be useful in your quest to identify and eliminate unnecessary costs and improve efficiency in your practice. For example, [pre-visit planning](#), [team documentation](#), and implementing [team-based care](#) are time-saving approaches that have helped other practices reduce costs.

Table 2.
Examples of cost-savings opportunities with value-based-care
Five suggestions and examples of opportunities to reduce cost

Cost savings opportunity	Example
Improving appropriate imaging	The practice consults appropriate use criteria before ordering imaging tests.
High-cost DME	The practice examines the cost of wheelchairs and switches to a lower-cost generic.
Unnecessary or outdated medications	The practice incorporates a medication management system to help patients better understand their medications. Pharmacists work one-on-one with patients to educate them on current medications and eliminate unnecessary prescriptions, thereby reducing costs.
Unnecessary or duplicate laboratory testing	The practice obtains results from outside facilities before the patient visit. Partner with a lab service that ideally has data integration capabilities to help eliminate unnecessary lab work when a patient receives services outside the practice.
Prevent avoidable hospitalizations and ED visits	The practice identifies the patient population(s) with the highest utilization of hospital and ED services and enrolls patients in care transition programs to decrease utilization.

5

Quantify impact and continuously improve

Continuously monitoring your progress will help you determine the impact you have on your target patient population. To achieve positive outcomes, reassess how well your practice is accomplishing the predetermined goals monthly or quarterly, and adjust your efforts as needed. You may want to consider using the [Plan-Do-Study-Act](#) (PDSA) method to track your success. Reevaluate your care model annually to ensure it is providing the desired impact. Regularly measure your patient, provider, and team member satisfaction as these are key to your model's success.

Keep an eye out for other value-based contracting options with payers and partners. Check your negotiated contracts on an annual basis to ensure you use the latest evidence-based metrics and receive appropriate financial compensation.

Each step on your journey to value-based care is a learning experience. Some decisions will work well, and some ideas will not work as planned. As these experiences provide your practice with more knowledge about what works best, the practice can make the changes that will better meet patient needs. Transparently and routinely informing your practice of the results of the value-based care model implementation, either in scheduled **team meetings** or with brief recaps during **huddles**, can help encourage the team to stay positive so they can continue to deliver value to patients.

Value-based care metrics

(MS WORD, 42 KB)

Q&A

Are there some examples of metrics that other practices have used?

CMS and commercial payers can provide you with a list of metrics specific to your practice that you can negotiate for value-based reimbursement. Due to competition, this type of information is typically not shared. Consider downloading and modifying the sample checklist of metrics from evidence-based medicine (EBM) guidelines to prepare for the negotiation process.

Are there any penalties in a value-based contract if I do not achieve my goals?

Whether your practice will be penalized for not meeting its goals depends on your contract. For example, there are upside-only contracts, which are contracts that do not assess any penalties for failing to meet specific goals. Any savings are typically shared evenly between the provider and the payer.

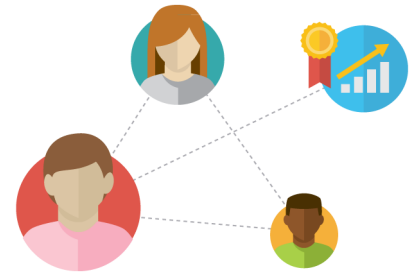
However, as success is achieved, you might want to transition to risk-based contracts that include potential penalties because these contracts also have the greatest potential for financial reward. Prior to signing any contracts, negotiate the gains and penalties you might receive and are able to accept. It is recommended that you work with qualified legal counsel when negotiating value-based contracts.

How can I involve patients in my new commitment to providing value-based care?

Patients can be involved and become responsible participants in their own health care. Intervening with high-risk patients between office visits with a simple phone call or connecting them with a **health coach** are ways you can engage patients in their health care. If your practice has a **patient and family advisory council**, involve them in your improvement efforts as well. Patients can be invaluable in helping shape the practice's value-based care model. **Social determinants of health** have a significant impact on the health of the patient, and should be considered when developing a treatment plan.

Conclusion

Value-based care models are the future of sustainable health care. This module is designed to help your practice make the shift towards this model so that your patients and team can reap the benefits of this outcomes-focused approach that incentivizes high quality, patient-focused care, and reduces overall health care costs.



AMA Pearls

Prioritize team communication when adopting the model.

When developing the new value-based care model, collaborate with physicians, physician assistants, nurse practitioners, nurses, leadership, and clinical staff to incorporate their insights and expertise. **Huddle** with your team every day to cover any gaps in care and patient goals that need to be addressed during that day's scheduled office visits. **Meet as a team** weekly or biweekly and include a review of **panel metrics**. These conversations are crucial to the success of value-based models. Consider sharing financial rewards with your team when goals are met.

Utilize data to continue to improve.

Use your data to improve your care. Do not underestimate the investment in IT infrastructure, applications, and database solutions required for the move to a value-based care model. When selecting a technology vendor, take into account their depth of knowledge in clinical and administrative processes related to care models, contracting, and care coordination – not just analytics. The quality of the data that goes into the system dictates the quality that comes out. Review of the correctness and appropriateness of the data used to determine whether quality and cost-containment goals are being achieved is often a more time-consuming task than expected.

The **AMA's Practice Management** guidance suggests the following⁶:

1. Electronic medical records are used to the fullest capacity.
2. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
3. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
4. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

Design roles that empower the care team.

A team-based approach to care is essential for successful implementation of a value-based care model. Create a strong **team culture** and empower the team to address the unique needs of each patient by using these other STEPS Forward™ resources:

- Team-based care
- Team documentation
- Pre-visit planning
- Expanded rooming and discharge protocols

Engage patients throughout the process.

Communicate proactively with your patients as a provider and as a practice. Keeping patients engaged and ensuring their experiences are positive in every interaction with you and your team is critical to your success in the transition to value-based care.

STEPS in practice

1

Value-Based Care Case Report: Cornerstone Health Care

Cornerstone Health Care, a multispecialty group in the triad region of North Carolina, decided to make the move to value-based care in several years ago. The organization transitioned from the traditional “fee-for-service” model to a patient-centered health care delivery system.

This value-based care model first implemented in a specialized heart clinic was designed to address the top 20 percent of their sickest chronic heart failure (CHF) patients. To be referred to the clinic, the patient must have an established cardiologist within the organization and meet one of the following criteria: ejection fraction <45% or documented diastolic dysfunction. The care model utilizes a team of three internists, an embedded behavioral health provider, embedded pharmacy services, a health navigator, and a nutritionist. A nurse practitioner (NP) and a health navigator work closely with the patient's cardiologist and other members of the health care team to create a treatment plan that is customized to the patient's individual needs. They also closely adjust medications to control the patient's symptoms and teach patients other strategies to control their symptoms. The health navigator makes calls between visits, monitoring the patient's progress closely and addressing any health care concerns.

After implementation, the team closely monitored the impact of this care model. The model started out as a separate clinic managed by a nurse practitioner that thrived on referrals from cardiologists and primary care providers. Ideally, the physicians would refer a patient to the clinic to help manage the patient's chronic heart conditions and to offer additional resources (pharmacy, behavioral health, nutrition, and social work) outside a typical office visit, all under the supervision and expertise of a nurse practitioner.

One of the struggles experienced with this model was the process of internally referring patients to the clinic, which involved transferring care to the heart function clinic from the traditional office practice of the physicians. The physicians resisted referring patients to the clinic because they saw referrals as a sign of “giving up” on their patients rather than co-managing their care. Another barrier was the additional copays that were required for each billable service provided. After a referral to the clinic, some patients refused to schedule follow-up office visits with the nurse practitioner because their insurance required this additional copay.

Despite these early challenges, savings on a per-patient basis were astounding—a result of greatly reduced numbers of hospitalizations. However, a certain enrollment number was necessary to offset operational costs. The organization struggled to approach this enrollment number for multiple reasons, including patients exiting the program and difficulties in securing referrals. For this model to achieve cost savings—and to break even—the clinic needed significantly more patients to be enrolled in the model. The current workflow was not achieving this, so Cornerstone began a redesign phase to address these and other issues. The team had to rethink the

workflow and enrollment criteria to encourage physicians to refer patients to the clinic and increase patient enrollment. The organization is currently negotiating with their full-risk contracts to appropriately waive copays for qualified high-risk patients, and the team is engaging physicians to identify the best possible workflow for co-management of care.

Despite the struggles and slow enrollment, this care model has had a great impact on their patient population and cost of care. In the three years since implementation, this care model has seen a per-patient cost-of-care savings of \$5,500 and overall cost-of-care savings of \$1.7 million for the 321 patients enrolled in the program. Most of these savings are based on comparing the total cost of care for the patients before they entered the program and their total cost of care after enrolling in the program. A reduction in hospital admissions because of improved outpatient management is the critical factor in the overall cost savings.

Cornerstone now has six specific care models to address their most vulnerable patient populations, and since implementation, they have seen positive outcomes resulting in more than \$3,000 per patient savings and more than \$6 million dollars in total savings on a total of 461 patients. They have also increased their patient and provider satisfaction by 43 percent and have a quality score of 94 percent, ranking them 6th in the nation.

Learning Objectives:

At the end of this activity, you will be able to:

1. Explain how to identify the patient population that is the best opportunity for value-based care;
2. List steps to design a care model;
3. Discuss ways to identify potential partners in the community to enhance the practice's ability to offer better transitional care and outpatient care management;
4. Demonstrate how to recognize unnecessary costs in your practice;
5. Describe steps to evaluate progress to determine the impact on the target population.

Article Information

About the AMA Professional Satisfaction and Practice Sustainability group: The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement: Unless noted, all individuals in control of content reported no relevant financial relationships.

Supported by Funding Opportunity Number 1C1CMS331067-01-00 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Contents of this module are solely the responsibility of the authors.

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