An Alternative Value-Based Care Model for Chronic Conditions

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Chronic diseases represent a growing burden of morbidity, mortality, and cost worldwide. Individuals requiring chronic care are most vulnerable to the type of care delivered under the fee-for-service (FFS) model, which is characterized by a lack of provider accountability, disjointed services, and incentives for volume rather than for quality or outcomes. The specialty care medical home (SCMH) is a hybrid of the patient-centered medical home (PCMH) and episode of care (EoC) models and provides an alternative value-based care model for this specific population.

Discussions about FFS and value-based care models often focus on payers and providers, but it is patients who are most affected by health care payment models, which dictate not only how care is paid but also how it is organized and delivered.

Under the prevailing FFS methodology, a provider renders care, a claim is submitted, and payment is determined based on whether the service provided is covered under the individual's health insurance plan. Because health care providers are paid in increments of care delivered, they typically focus only on the care they themselves render, without necessarily considering care the patient receives from other providers. Most importantly, payment is made without regard to patient outcomes. The FFS system does not contemplate whether the individual patient actually got better or benefitted from the care. The result is a fragmented and inefficient system of health care delivery for all—and one that is particularly challenging for individuals with chronic conditions, who are among those most adversely affected by the FFS payment model.

Chronic conditions, as defined by the Centers for Disease Control and Prevention, are those that last one year or more and require ongoing medical attention or limit activities of daily living, or both.[1] People with chronic conditions often have multiple chronic diagnoses, whether physical (eg, diabetes and hypertension, psoriatic arthritis and cardiovascular disease) or behavioral and cognitive (eg, ongoing depression, substance addiction, or dementia).[2] In addition, given that approximately 90% of the nation's $3.5 trillion in annual health care expenditures are for people with chronic physical and mental conditions,[3] even a small improvement in care for this population could have a significant impact on lowering health care costs nationally.

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Addressing the comorbidities that typically accompany a chronic diagnosis usually requires multidisciplinary care. However, the fragmentation of the FFS model forces patients to navigate a complex labyrinth of services on their own, without the benefit of understanding how the care of one provider interacts with and affects the care being rendered to them by another provider. For their part, the providers themselves are also often unaware of what else happens to the patient once they leave their office.

This lack of coordination leads to duplicative and potentially unnecessary care. Further, individuals with chronic conditions sometimes receive conflicting counsel from physicians and other health care providers, who treat only one portion of the individual's overall health. In addition, such individuals often have significant functional limitations that can complicate their access to health care and interfere with self-management. Their out-of-pocket costs are also typically extraordinarily high, further affect-

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ing both access to health care and their ability to withstand the complexities of their illnesses.

In prior articles in this column, I have written about modifying EoC models to address chronic conditions.[4] Because chronic conditions are complex and often have multiple comorbidities, improving the overall health of patients with these conditions—as well as managing delivery costs—requires that care be well-coordinated and synchronized. While it is possible to modify the EoC model to do this, the care for a chronic condition is not really episodic in nature. In the present column, I propose that a better alternative might be a different kind of value-based care model: an SCMH , which is basically a hybrid of the PCMH and EoC models.[5]

COMPARING VALUE-BASED CARE MODELS

First, a quick review of the most common value-based care models. In primary care, the most common models are the accountable care organization and the PCMH. These are both population health models; they typically have heterogeneous populations of people attributed to them, and their job is to keep that population healthy (eg, making sure patients get flu shots, mammograms, colonoscopies, etc). In specialty care, there are EoC and bundled payment models, both of which have much more homogenous populations (ie, populations stratified either by the type of disease or the type of procedure) and whose goals are to reduce and optimize the variation in and cost of the care among that group.

Regardless of the model's name or methodology, the goal for each is the same: to improve patient outcomes and experience; to reduce overall costs by improving collaboration, communication, and coordination across the health care continuum; and to create accountability to the individual patient.

The EoC and bundled payment models work well for procedures, ie, services that are "one and done" with an easily identifiable start and end date. Care and costs related to the procedure or the diagnosis can be easily measured within the episode's relatively short timeframe. Chronic conditions, on the other hand, generally do not have specific start and end dates, and "related" care can be difficult to define (**Box 1**). Therefore, the best model for patients with chronic conditions may be the SCMH, as it befits a population in need of specialized, coordinated care, usually for many years and/or a lifetime.

- Individuals living with chronic conditions are among those most adversely affected under the FFS payment methodology.
- Those with chronic conditions tend to require more care, have multiple comorbidities, and require care from multidisciplinary providers.
- Incremental units of payment have led to fragmented and disjointed care, which, for those living with chronic conditions, can be dangerous and unnecessarily costly.
- Typically, the principle point of contact for someone with a chronic condition is the specialist who addresses the primary diagnosis (ie, that physician acts as the individual's primary provider).
- Care is ongoing (ie, there is no end point as in a procedural episode).
- Creating team-based care, with incentives for creating accountability to the patient, ensures that each individual receives a comprehensive care plan customized to their specific diagnoses and needs, creating efficiency in resources and spending

Box 1. Perceived prevalence of EGFR mutations.

THE SPECIALTY CARE MEDICAL HOME MODEL

An SCMH integrates care among multiple disciplines and specialties on an *ongoing* basis. Unlike a PCMH, which has a very diverse patient population, an SCMH includes a more precisely stratified population, ie, those who have some clinical similarity, as it relates to their primary diagnosis (eg, an SCMH for people with inflammatory bowel disease or diabetes). The SCMH has expertise and support specifically for the condition(s) being managed. Also, since the specialist who treats the primary diagnosis is the patient's primary point of contact with the health care system, that specialist is well suited to take on the role of principal care provider and coordinator of all care.

Again, like all value-based care models, a successful SCMH requires regular communication, collaboration, and coordination across the health care continuum. This does not mean, however, that all care partners must be physically co-located; it is not a physical "home" we are creating. A virtual model can work extremely well. In fact, one thing the COVID-19 pandemic has taught us is how effective virtual communication and collaboration can be and that we can actually extend the reach of our partnerships and improve outcomes by engaging those most effective rather than those most proximate.

A successful SCMH would create a team that is accountable to the patient, who would affirmatively monitor what is happening with the patient at all points and ensure that all treatment therapies are addressed and in sync. It requires that all health care parties focus on the same goals decided by the multidisciplinary team.[6] Again, it does not require that parties be together in person.

Deciding on metrics to measure outcomes, like in all value-based care models, is best done in collaboration with the team of stakeholders. Clinical and claims data are used to assess the drivers of care and cost variation, which help prioritize where the team needs to focus its attention. The data is also used to inform decisions about which providers and care partners are key to be included

in the SCMH, who might be the lead, and what outcomes metrics should be measured.

The financial model for an SCMH can be much simpler than one for an EoC model, which often requires a complicated algorithm designed to capture only care related to the procedure or primary care diagnosis. Since an SCMH is about all of the care rendered to an individual in an ongoing manner, the financial model can be based on the total cost of care (ie, a model that includes all care and costs), which is precisely the point of the medical home. The good news is that a total-cost-of-care model is among the easiest to execute and measure and can be easily run and captured by health plans.

Like all value-based care models, SCMH models require respect, collaboration, and a willingness to leverage the expertise of those who might formerly have been adversaries. Health plans will need to share longitudinal claims data with providers to enable the care team to identify not only the most effective providers but also any inefficiencies in care. Pharmaceutical companies can provide insight into patient journeys and help explain issues affecting prescription medicine and other protocol adherence, which they study exhaustively. Payment is made based on agreed-upon outcomes, and there is an opportunity to consider nontraditionally covered services (ie, transportation, meditation, peer counseling, etc) and digitally enabled patient engagement and symptom management solutions in the care delivery continuum.

CONCLUSION

It is critically important to bring together these and other stakeholders—traditional and nontraditional alike—to effectively care for those who are most vulnerable and who have been most adversely affected by the FFS payment model. The SCMH creates a "home" for individuals living with chronic conditions and ensures that they receive the comprehensive care that enables them to have productive, healthy lives without the added stress, danger, and costs associated with having to navigate on their own. ◆

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