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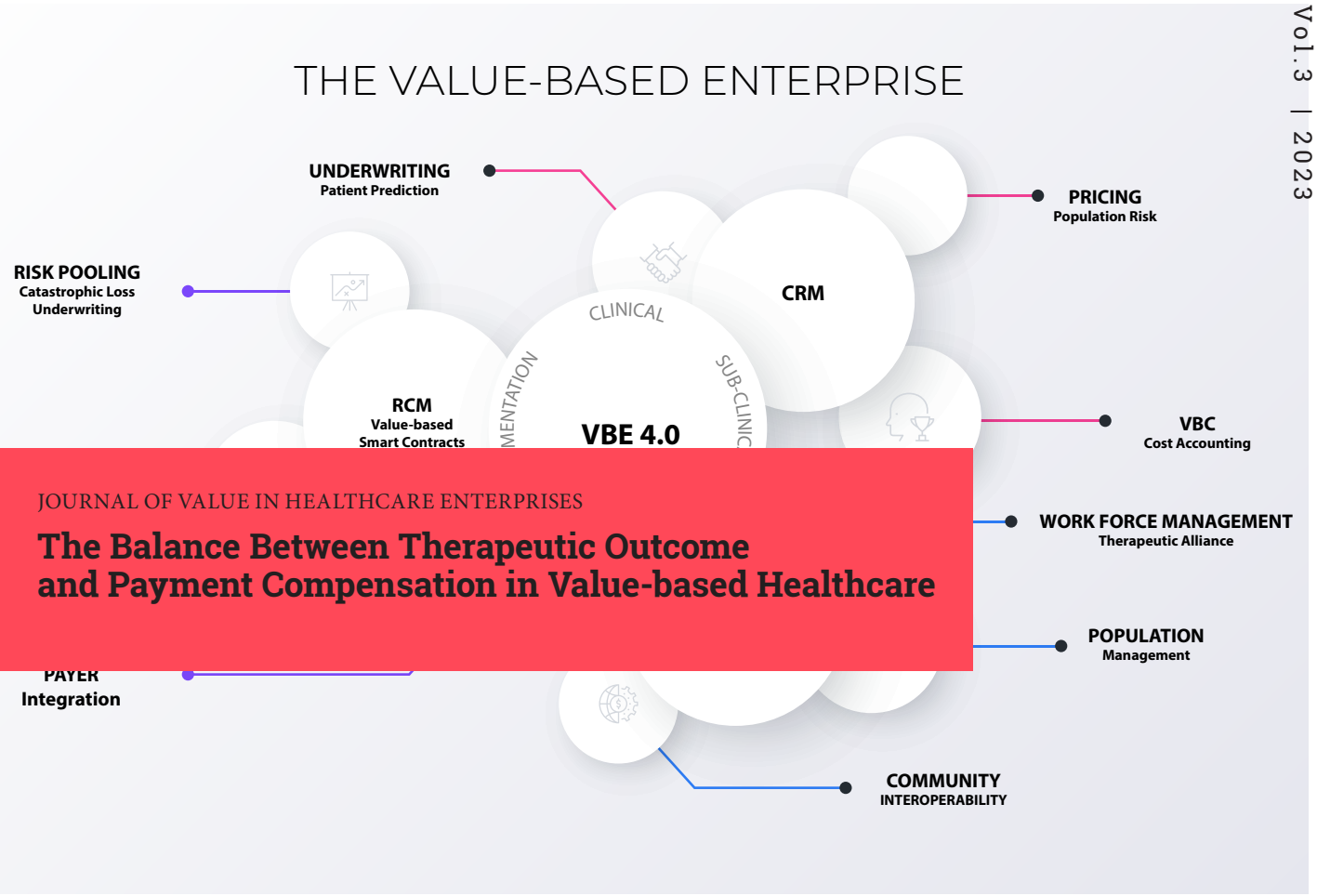

JOURNAL OF VALUE IN HEALTHCARE ENTERPRISES

The Balance Between Therapeutic Outcome and Payment Compensation in Value-based Healthcare

youu HEALTH

Contents

Articles

The Balance Between Therapeutic Outcome and Payment Compensation in Value-based Healthcare

Rethinking compensation for delivering behavioral health using a shared responsibility approach and the strategy needed to get there.

Should therapists accept, or share, the risk of a patient's outcome in exchange for payment?

This is one of the most important questions facing mental and behavioral healthcare. After all, it is a critical driver in the economics of the overall healthcare system, especially when serving patients with diverse needs and challenges difficult to measure. But, perhaps most enigmatic among the industry's discussion is the artful balance between therapeutic outcomes and an evolving expectation about how value-based compensation will work, and how the industry will achieve this goal after years of conjecture.

This paper aims to examine these dynamics and propose specific solutions to structure a compensation model for managing a value-enabled health system. Moreover, it emphasizes specifics, including the significance of patient reporting in defining success and discusses its relevance within the context of a value-based care model. And, among other topics, it questions whether our current HealthIT adequately supports the necessary workflows to control the financial reporting, cost controls, risk underwriting and outcome accountability required for the value-centric enterprise of the future.

Defining the Joint Responsibility of Patients and Therapists

The success of a patient's recovery is influenced by a triad of factors including the skills and expertise of the therapist, the patient's commitment to treatment, and the level of therapeutic alliance and collaboration between the two parties. It is important to consider whether the responsibility of a successful outcome should be shared between the patient and the therapist. While therapists provide guidance, support, and service interventions patients must actively engage in their treatment, follow recommendations, and take responsibility for their own well-being. This shared responsibility acknowledges the mutual commitment required to achieve positive therapeutic outcomes.

But a tension exists in how to design a compensation model that appropriately distributes the risk and reward among the parties. This chicken and egg paradox often belies the facts when placing too much dependence on either parties' contribution. When applied to an infinitely variable definition of what success means with a chronic disease, such as is found with behavioral health, finding a solution can take on some complex analytics. Providers aren't accustomed to dealing deep data sets and actuarial financial risk — not because they can't — but because they haven't been introduced to the

structure to support it. Addressing the enterprise limitations found in the electronic medical records technology currently supporting their practice is a fundamental obstacle to value-oriented workflows.

A Occam's Razor Moment for Payers

The payer, of course, is the central actor and economic moderator in this value equation; and itself worthy of the Occam's Razor principle. Compensation, when applied to the payer's rather difficult role and responsibility in chronic disease, suggests the simplest solution to address payment for care is to move away from traditional fee-for-service liabilities altogether — while tossing the systems that limit their path to value. The complexity of chronic disease requires a more comprehensive and holistic approach to care, rather than a fragmented system designed for payment workflows that incentivizes quantity over quality.

The historical ambition of embracing alternative reimbursement models, such as value-based care or bundled payments, anticipated payers could align incentives with patient outcomes and promote effective, efficient, and coordinated care for individuals with complex chronic conditions. These models would emphasize preventive measures, care coordination, and patient engagement, leading to improved health outcomes and the reduction of costs in the long run. And, when again considering Occam's Razor, these alternative models might come down to simply freeing healthcare workers to practice imaginative care versus institutionalizing inefficiency with "practice by allowable billing code" or often non-reproducible "evidence-based" structural formulae.

Adapting to value-based care models presents significant challenges for payers, but also offers opportunities to transform the healthcare landscape. By overcoming the challenges of transitioning payment models, integrating data, fostering collaboration, and implementing effective risk adjustment strategies, payers can drive improved quality, cost efficiency, and population health outcomes.

Payers Face Four Principle Challenges

Payers need new infrastructure. Transitioning from the traditional fee-for-service reimbursement model to value-based reimbursement arrangements is a shift requiring payers to develop new payment structures and contracts that align with the goals of value-based care. Payers must also invest in robust data analytics capabilities to measure and track outcomes accurately.

Payers data Integration and interoperability. Value-based care models heavily rely on collecting and analyzing vast amounts of data from various sources, including electronic health records, claims data, and patient-reported outcomes. Payers need to overcome the challenge of integrating data from disparate systems and ensuring interoperability. This may involve investing in technology infrastructure, data sharing agreements, and data governance frameworks.

Payers need collaboration from providers. The success of value-based care hinges on close collaboration and alignment between payers and healthcare providers. Payers must establish strong relationships with providers to foster trust, share data, and develop shared goals and incentives.

Payers need risk adjustment and stratification. Value-based care models often involve assuming financial risk, such as capitated payments or shared savings arrangements. Payers must accurately assess and adjust for the risk profile of their patient populations to ensure fair reimbursement and prevent adverse selection. Risk adjustment methodologies need to be robust and accurately account for the complexity of patient conditions to avoid penalizing providers unfairly.

ARTICLE

The Role of Electronic Medical Record Systems in Adaptation to Value-based Care Models

ABSTRACT: The transition from fee-for-service to value-based care in healthcare is hindered by the challenges faced by electronic medical records (EMR) systems. Originally designed for billing and clinical documentation, EMR systems struggle to capture patient outcomes and value, impeding the implementation of value-based care models. Interoperability issues between different EMR systems and point solutions further complicate the exchange of patient information, hindering coordinated care and value-based initiatives. Moreover, the complexity and cost of implementing new functionalities within existing EMR systems present significant barriers to their adaptability. To effectively transition to value-based care, EMR systems need to be reimagined, redesigned, standardized, and made interoperable, or possibly replaced altogether. The VBE 4.0 model addresses the missing functional workflows in the EMR model by incorporating risk underwriting, cost accounting, and correlation of patient outcomes. By integrating value control components such as risk pooling, smart contracts, and cost accounting, the VBE model enables providers and payers to project and price outcomes. The inclusion of digital health and artificial intelligence technologies allows for the collection of patient-reported data and supports population health management. The interconnected enterprise model further enhances care coordination and scalability, positioning the patient as a population cohort within a larger community.

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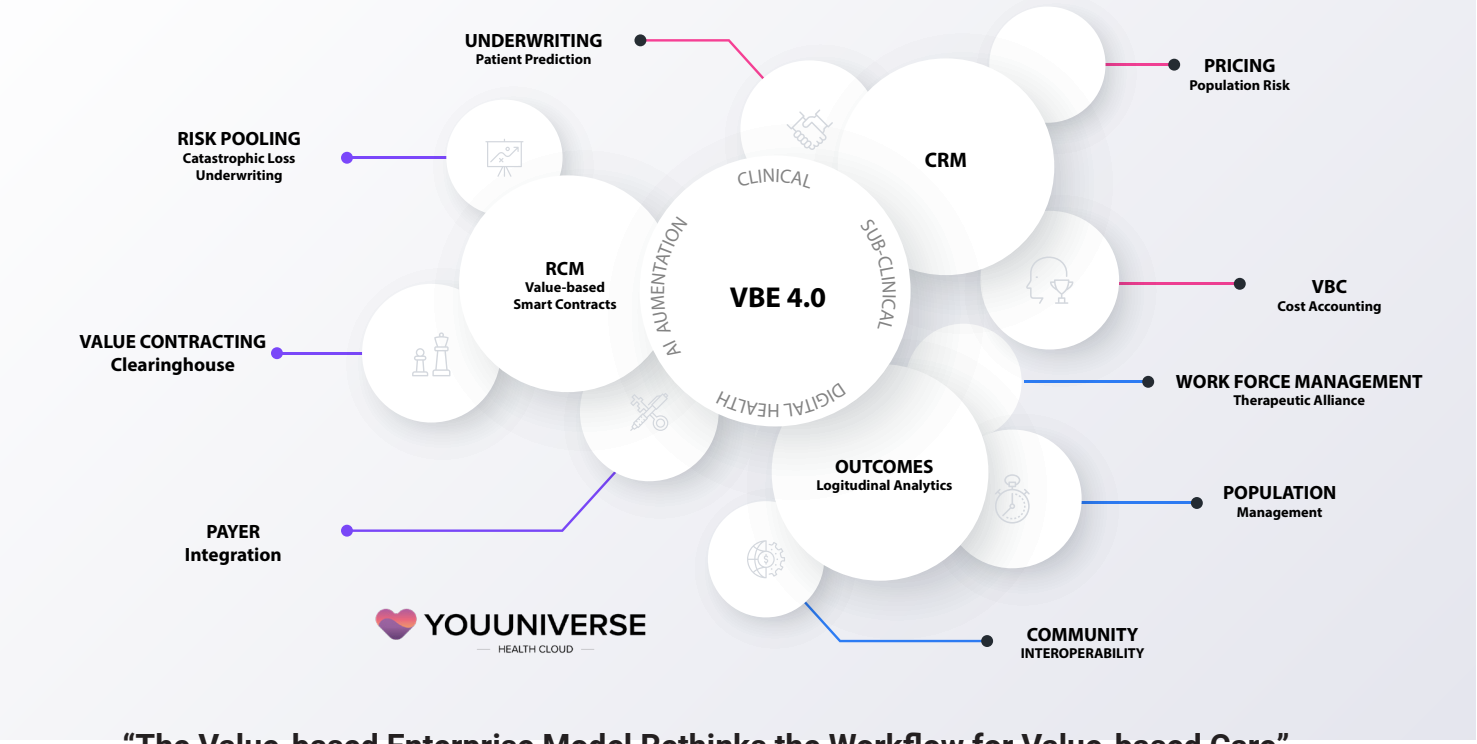
KEYWORDS: Electronic medical records, Value-based care, Fee-for-service problem, Risk underwriting, Healthcare Interoperability, Patient outcomes, Coordinated care, Value Based Enterprise VBE 4.0.

INTRODUCTION

Healthcare's electronic medical records (EMR) systems face insurmountable challenges in adapting to value-based care for several reasons. One can make a serious case that the EMR perpetuates the fee-for-service problem by institutionalizing a failing payment model. Primarily, EMR systems were initially designed to automate billing and clinical documentation, rather than capturing patient outcomes and value. This makes it difficult to collect and analyze the necessary data for value-based care models. Additionally, interoperability issues between different EMR systems and point solutions attempting to mitigate it frustrate the seamless exchange of patient information across healthcare providers, thus eliminating the possibility of coordinated care and value-based



“The Value-based Enterprise Model Rethinks the Workflow for Value-based Care”

The YOUUniverse.ai VBE 4 from Youu Health

initiatives. Furthermore, the complexity and cost of implementing new functionalities within existing EMR systems pose major barriers to their adaptability.

To effectively transition to value-based care, EMR systems need to be reimagined, redesigned, standardized, and made interoperable while prioritizing outcomes and patient-centered care – or simply replaced. That’s a tough challenge for the EMR for what is, by today’s technology standards, outdated.

MOVING FROM EMR TO THE VBE 4.0

Addressing Risk, Outcomes & Cost

There are three functional workflows currently missing in the EMR model; the ability to underwrite and predict risk, cost accounting and the correlation of patient outcomes to the prior two. In the VBE model the common components of the CRM, EMR and RCM have been extended to include value control components such as risk pooling, smart contracts that interact with payer integration, cost accounting that supports capitated or bundled payment performance and the payer/provider audit supporting both value or fee-for-service billing.

These enhanced capabilities enable the provider and payer to project and price an outcome while a digital health connected patient can deliver hundreds, if not thouands of patient reported data supported by augmented intelligence and Large Language Models of artificial intelligence technology.

Additionally the interconnected enterprise model makes the goal of solving the broader population health more attainable as care teams can be organized from any combination of individuals or organizations thus positioning the patient as a population cohort within a scalable community.

ARTICLE

The Role of Pooled Risk and Component Reserve Pools

ABSTRACT

This paper summarizes the concept of funding a reserve pool in value-based care compensation to mitigate the negative consequences of assuming risk. The reserve pool serves multiple purposes, including risk mitigation, long-term planning, financial stability, and flexibility. By allocating funds to the reserve pool, providers can cover unforeseen expenses and address long-term needs without disrupting regular operations or resorting to borrowing. Reinsurance can be utilized to distribute risk broadly and protect surplus reserves, while commercial insurance contracts offer additional coverage for losses beyond the reserve pool. The proactive financial strategy of funding a reserve pool aligns payment with overall care management, encouraging the delivery of high-value care. Reserve pools act as a backstop framework, protecting against downside risk while incentivizing outcome innovation. This approach recognizes the irregularity and inadequacy of care received by patients, particularly vulnerable populations, and aims to improve outcomes while lowering costs. The concept of reserve pooling offers financial security and stability for providers while promoting better care delivery.

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KEYWORDS: Value-based compensation: Reserve pool: Risk mitigation: Outcome innovation: Healthcare risk management: Value-based care models:

AVOIDING RISK

When risk is assumed, providers will need some sophistication in avoiding its negative downside consequences. Perhaps the most common reluctance for adopting value compensation is the reluctance associated with this financial downside. However, the financial markets have solved this common finance problem outside the healthcare market. Value-based compensation demands a new financial instrument, the reserve pool. Funding a reserve pool involves setting aside funds to protect against future risks and uncertainties — particularly catastrophic loss. The concept behind this practice is to establish a financial cushion that can be used to cover unexpected expenses, mitigate potential losses, or address long-term needs. In the context of value-based care compensation, a reserve pool supplements earned service fee with an earned premium on that service and is set aside

so the provider practice is financially secure and prepared in the event a patient experiences a costly set back in care.

Reserve pools serve several purposes, including:

Risk Mitigation: By allocating funds to a reserve pool, providers can mitigate the impact of unexpected events or emergencies. These funds act as a buffer to cover unforeseen expenses, reducing the need for immediate external financing or disrupting regular operations.

Long-Term Planning: Reserve pools are often used to address long-term needs, such as patient readmissions, extended acute stays, and capital or workforce improvements. By consistently funding the reserve pool, organizations can accumulate resources over time to meet these unanticipated expenses without straining their regular patient income, budgets or resorting to borrowing.

Financial Stability: Having a well-funded reserve pool enhances financial stability and confidence. It demonstrates an organization's ability to handle unforeseen circumstances, instilling trust among stakeholders, investors, or members.

Flexibility: Depending on the specific funding method chosen, reserve pools can offer flexibility in how the funds are utilized. For example, pooled account funding allows expenses to be covered for any reserve asset without requiring member or payer approval.

The Role of Reinsurance for Catastrophic Loss

Overall, funding a reserve pool, and reinsuring it to distribute risk broadly, is a proactive financial strategy that allows the provider to protect a surplus reserve as potential profit when the pool exceeds its reasonable capacity and when a catastrophic loss can be easily absorbed by the practice. Further, re-insurance, or commercial insurance contracts can be underwritten to satisfy losses beyond the reserve pool, in exchange for a premium, like other insurance contracts. These policies are custom and can be underwritten as a group policy to ensure small providers enjoy loss protection.

Reserve pools offer a backstop strategic framework to enable a larger goal of better outcomes while often lowering costs. It also recognizes that the quality of care received by patients is often irregular or inadequate, and poor-quality care is common across conditions and countries, with the most vulnerable populations faring the worst. Value-based care models with reserve pooling align payment with the overall care management for a patient population, encouraging market-based delivery of high-value care.

"Reserve pools offer a backstop strategic framework to enable a larger economic goal. It protects against downside risk while aligning compensation with incentives that allow for outcome innovation."

ARTICLE

The Role of Measurement In Value Compensation

ABSTRACT: Determining compensation based on therapeutic outcomes involves considering various factors, including the quality of therapeutic outcomes, patient satisfaction, cost-effectiveness, adherence to evidence-based practices, and continuity of care. These factors play a crucial role in value-based care models, which aim to achieve better outcomes while lowering costs. Quality of therapeutic outcomes encompasses the effectiveness of interventions and the resulting improvement in the patient's health condition. Reduced symptoms, improved functional abilities, and overall patient satisfaction are key considerations. Patient satisfaction, reflecting the patient's experience and perceived quality of care, is essential in value-based care. Cost-effectiveness evaluates the balance between intervention costs and health improvements. Adherence to evidence-based practices ensures positive outcomes, with healthcare providers following established guidelines and best practices. Continuity of care involves coordinating services and providing consistent care throughout the patient's healthcare journey. To develop a compensation structure aligned with patient outcomes, relevant measures of success must be identified. Task completion, objective measurements, and milestone accomplishments are three measures that can be considered. Patient reporting is also crucial, as it allows therapists to understand individual perspectives, needs, and goals, ensuring that the compensation structure aligns with the patient's unique recovery journey.

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KEYWORDS: Therapeutic outcomes: Patient satisfaction: Evidence-based practices: Continuity of care: Healthcare measurements

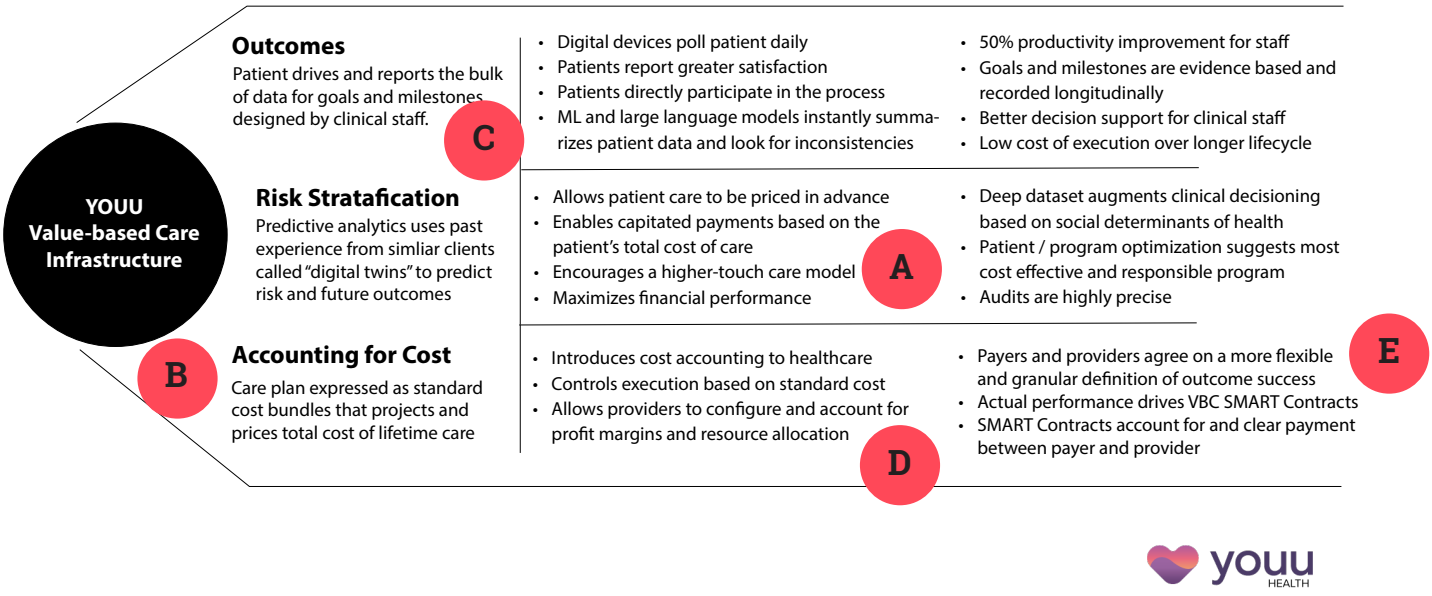
OUTCOMES AND COMPENSATION

When determining compensation based on therapeutic outcomes, several factors may be considered. These factors can vary depending on the specific payment model and the healthcare organization. Here are some key factors that may be taken into account:

Quality of Therapeutic Outcomes: The effectiveness of the therapeutic interventions and the resulting improvement in the patient's health condition are important considerations. This may include factors such as reduced symptoms, improved functional abilities, and overall patient satisfaction.

Patient Satisfaction: Patient satisfaction is an essential aspect of value-based care. It reflects the

Distinctive operational capabilities are prerequisites for successful value-based care providers



patient's experience with the healthcare provider and the perceived quality of care received. Patient satisfaction surveys and feedback can provide valuable insights into the effectiveness of therapeutic interventions.

Cost-Effectiveness: Value-based care models aim to achieve better outcomes while often lowering costs. Therefore, the cost-effectiveness of therapeutic interventions may be considered when determining compensation. This involves assessing the balance between the cost of the intervention and the resulting health improvements.

Adherence to Evidence-Based Practices: The use of evidence-based practices in therapeutic interventions is crucial for achieving positive outcomes. Healthcare providers who adhere to established guidelines and best practices may be rewarded in compensation models that prioritize value-based care.

Continuity of Care: Continuity of care refers to the coordination and integration of healthcare services across different providers and settings. It ensures

A Underwriting a patient in advance of care allows the provider to price for care and risk

B Cost accounting principles help providers understand the granular details of the standardized cost of providing care to a patient.

C Outcomes driving value-care are dependent on frequent collection of patient provided data over long periods of time.

D SMART contracts allow providers and patients capitate, or bundle value contracts that are digitally tracked and triggered as patient milestones are met.

E Value-care allows for flexible care plans at the patient level and payer/provider interconnectivity allows for compliance to individual cohort plans or with individual high-risk patients.

that patients receive consistent and seamless care throughout their healthcare journey. Compensation models may consider the ability of healthcare providers to facilitate continuity of care and promote care coordination.

The Role of Success Measures in Compensation Structures:

To develop a compensation structure that aligns with patient outcomes, it is crucial to identify relevant measures of success. Three specific measures that can be considered are:

Task Completion: This measure assesses the patient's ability to accomplish specific treatment-related tasks, such as attending therapy sessions, adhering to medication regimens, or engaging in self-help activities. Task completion demonstrates the patient's commitment and active participation in their recovery process.

Objective Measurements: Incorporating objective measurements, such as symptom reduction or improvement in functioning, provides a quantifiable assessment of therapeutic progress. These measurements can be derived from standardized assessments, self-reported scales, or clinical observations, providing an objective basis for evaluating treatment effectiveness.

Milestone Accomplishments: Tracking the patient's progress over a longitudinal timeline can help identify significant milestones in their recovery journey. These milestones may include improved interpersonal relationships, increased resilience, or the achievement of specific treatment goals. Milestone accomplishments provide a holistic view of the patient's progress and serve as markers of successful recovery.

The Role of Patient Reporting in Defining Success and Value

Patient reporting is a valuable tool in defining what success looks like in their own recovery. By actively involving patients in the evaluation and definition of success, therapists can gain insights into their unique perspectives, needs, and goals. Patient-reported outcome measures (PROMs) provide a means to capture these subjective experiences and perceptions, ensuring that the compensation structure aligns with the patient's individual journey towards recovery.

In conclusion, when determining compensation based on therapeutic outcomes, several key factors are taken into consideration. These factors include the quality of therapeutic outcomes, patient satisfaction, cost-effectiveness, adherence to evidence-based practices, and continuity of care. Additionally, the use of success measures is crucial in developing a compensation structure that aligns with patient outcomes.

These measures include task completion, objective measurements, and milestone accomplishments. Furthermore, patient reporting plays a vital role in defining success and value, as it captures the subjective experiences and perceptions of patients. By considering these factors and involving patients in the evaluation process, healthcare organizations can ensure a compensation structure that prioritizes value-based care and promotes successful recovery.

ARTICLE

The Role of Innovation within Free-to-Practice Compensation Models

FREEDOM TO PRACTICE & INNOVATE

Innovation should play a vital role in healthcare, especially when combined with a free-to-practice compensation model that prioritizes patient outcomes over fee-for-service workflows.

By shifting the focus from quantity to quality of care, this model incentivizes providers to prioritize patient outcomes and adopt holistic approaches. Unlike the traditional fee-for-service requirement, the Free-to-Practice model discourages care that is solely driven by a chase for the billing code, enabling therapists to focus on the well-being of their patients.

One of the significant advantages of the VBE model is that it encourages the exploration of alternative therapies, cutting-edge treatment methods, and personalized interventions. Therapists have the flexibility to think outside the box and experiment with innovative approaches that may yield better outcomes for their patients. This freedom allows for a more comprehensive and individualized approach to care, catering to the unique needs of each individual seeking behavioral healthcare.

Furthermore, the introduction of value-based compensation structures empower providers to invest in research and development. This creates a fertile ground for groundbreaking advancements in behavioral healthcare. As a result, the field of behavioral healthcare can experience significant growth and improvement, ultimately benefiting patients and the healthcare system as a whole.

Another promising aspect of this shift towards value-based compensation is the promotion of collaboration among professionals. By focusing on patient outcomes therapists are encouraged to work together, exchanging knowledge and expertise. This collaboration enhances the development and implementation of innovative strategies that address the complex and diverse needs of individuals seeking behavioral healthcare. By pooling their resources and expertise from integrated communities of care teams, professionals can collectively improve the quality of care and create a more robust support system for patients.

Conclusion

IN CONCLUSION

The balance between therapeutic outcome and payment compensation in mental and behavioral healthcare requires a comprehensive understanding of the shared responsibility between patients and therapists. By considering the patient's perspective, therapists can develop compensation structures that reflect the value of successful outcomes. Incorporating measures of success, such as task completion, objective measurements, and milestone accomplishments, provides a framework to assess and reward positive therapeutic outcomes. Moreover, patient reporting plays a crucial role in defining success and ensuring that the compensation structure aligns with the patient's unique recovery journey.

Embracing a value-based care model that prioritizes patient-centered outcomes can lead to improved quality of care and better compensation practices in mental and behavioral healthcare. This model aligns payment with the overall care for a patient with a particular medical condition, encouraging teamwork and high-value care. It emphasizes preventive measures, care coordination, and patient engagement, which can lead to improved

health outcomes and reduced costs in the long run.

However, the current electronic medical records (EMR) systems face challenges in adapting to value-based care. These systems were initially designed to automate billing and clinical documentation, rather than capturing patient outcomes and value. Interoperability issues between different EMR systems also hinder the seamless exchange of patient information across healthcare providers, eliminating the possibility of coordinated care and value-based initiatives. To effectively transition to value-based care, EMR systems need to be reimagined, redesigned, standardized, and interoperable, prioritizing outcomes and patient-centered care.

Rethinking compensation for delivering behavioral health requires a shift towards a shared responsibility approach for successful recovery. This includes designing compensation models that appropriately place the risk and reward distribution on both patients and therapists. By embracing alternative reimbursement models, such as value-based care or bundled payments, payers can align incentives with patient outcomes and promote effective, efficient, and coordinated care for individuals with complex chronic conditions. Additionally, the use of reserve pools and reinsurance can provide financial stability and protection against catastrophic losses. Overall, a value-based care model that incorporates patient reporting and measures of success can lead to improved quality of care and better compensation practices in mental and behavioral healthcare.

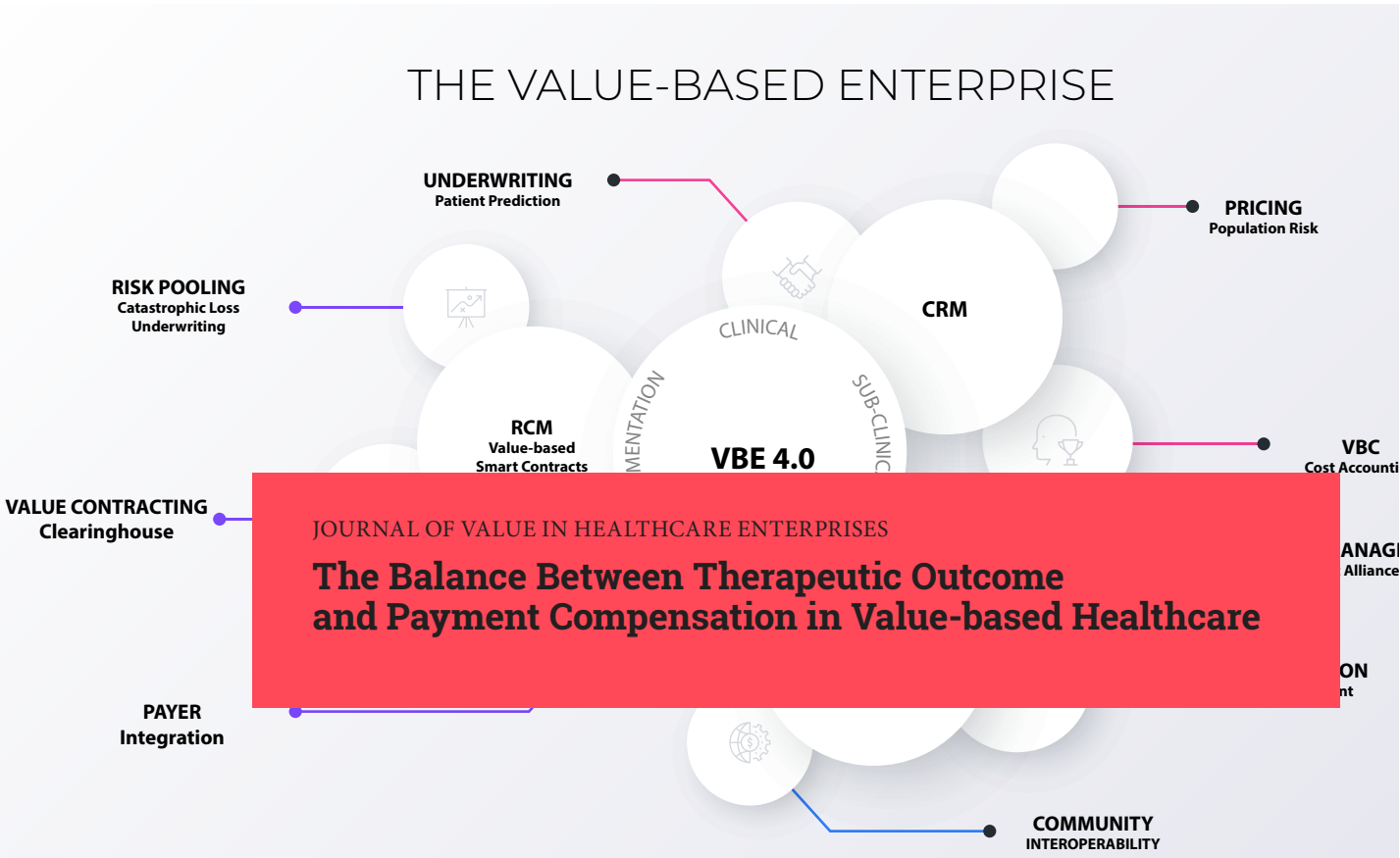
About YOUU Health

YOUU Health is an electronic health cloud platform and the first enterprise platform designed specifically for value-based care models. We operate a family of healthy community health technology platforms. We serve many vertical applications and all acuities from hospitalization, partial hospitalization, outpatient, continuing care and lifestyle communities that encourage treatment, prevention and personal development.

These communities are part of three important health segments; mental and behavioral health and personal development. We serve providers and payers who serve clients with a life-controlling issue or non-clinical community management for self-improvement and personal growth.

We operate worldwide in over 125 markets, in 9 countries, where any community builder can now reach anywhere in the world to hyper-connect other communities to build the size, scope and revenue opportunity large markets have to offer. If you're a single physician, or a multi-state clinical operator, a faith-based entity, a university or virtual community, we've got an easy-to-use solution for "youu".

We're revolutionizing community building by transforming client engagement through augmented intelligence. It delivers hyper-personalized support that exceeds human capabilities with real-time assistance and data-driven insights. It's the future of healthcare.



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