

Alternative Payment Models and Team-Based Care

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Team-based care delivery models offer opportunities to improve quality of care and outcomes for patients, providers, and communities. Because of various barriers, including disincentives in the payment system, team-based care has not reached its potential. This commentary discusses team-based care in the context of emerging value-based payment models and the potential costs of, and opportunities afforded by, these models.

Introduction: Team-Based Care

Team-based care is “the provision of health services to individuals, families, and/or their communities by at least 2 health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care [1].” This definition points to the value of collaboration in health care, which is generally not questioned. Health professionals often work together to deliver care. However, what is different with team-based care is the deliberate, intentional integration and the collaboration of health professionals to deliver care. Team-based care thus involves integration, coordination, collaboration, and facilitation of care across individual team members and providers. It also includes the purposeful inclusion of patients and families in the team.

The shift to team-based care is not without challenges. Generally, it is a struggle to create well-structured and sustainable high-performing teams, especially in systems that have not typically operated under such a model. There are also barriers to implementing team-based care, including the physical, regulatory, and disciplinary “silo” structures that separate providers and prevent collaboration; the disciplinary mindset of health professions education and training; the professional rivalries; and the disincentives in payment systems [2].

Recently, team-based care has gained momentum due to legislative actions such as the Affordable Care Act, the Medicare Access and CHIP Reauthorization Act, and the efforts of groups like the Patient-Centered Primary Care Collaborative and the Interprofessional Education Collaborative (IPEC). In addition, key reports offer principles of team-based care and strategies for building effective teams [1, 3]. This commentary examines the types of health

care teams, the emerging payment models, the opportunities and challenges of these models, and finally thoughts on the future of team-based care.

Types of Health Care Teams

There are diverse types of teams in health care that generally have 3 common attributes: shared goals, shared responsibility for care delivery, and a defined, bounded, and clearly understood membership [2]. Mosser and Begun categorize teams based on their purpose, scope, duration, stability of membership, and leadership [2]. Clinical teams, the most prevalent type of teams, can be of long or short duration. Those of longer duration provide care and services to patients over an extended period of time and for recurrent or episodic care [2]. A good example of this type of team is a primary care team that cares for patients over years, in times of both health and periodic illnesses. These teams are established as “permanent” teams in terms of their relationship with patients and tend to have a relatively stable membership and clear leader. Shorter-term clinical teams typically come together to provide care for time-limited episodes with members rotating in and out as needed but having clearly defined roles and a designated leader [2]. An example of such a team is a rapid response team in a hospital, which comes together to provide care to a patient and generally has a defined set of team members who serve in roles such as team leader and scribe, as well as specific types of clinical experts.

Understanding the purpose of the team is important in overcoming challenges of adoption, implementation, and maintenance. Also, the focus of the team will determine its composition, the potential costs to the organization, and the possible impacts on patient care. For example, it might be expensive and time consuming to implement and sustain a new chronic care team in primary care, but the team might be cost effective over the long run in caring for a specific set of patients [4].

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Emerging Payment Models

In the past, the payment systems did not incentivize the implementation of teams to deliver care, however that is changing with new payment models. New payment models launched by CMS have been catalysts in fostering the use of team-based care. These models have shifted clinical and financial accountability to providers, by reimbursing providers based on certain cost, quality, and patient experience metrics. Providers are incentivized through these models to innovate and seek ways to provide high-quality care while minimizing costs. Research has demonstrated the positive effects of team-based care. For example, implementing transitional care teams in acute care reduces costs and patient readmissions, and increases provider and patient satisfaction [5]. In primary care, evidence shows that team-based care improves patient and provider satisfaction, lowers rates of health care utilization (eg, emergency department visits, ambulatory care visits, and primary care physician encounters), and lowers post-discharge mortality [6-8].

The Alternative Payment Model (APM) Framework classifies payment models into 4 categories. An important point is that different types of providers may face financial gains or risks under different payment models. The first 3 categories include payment models that use some degree of traditional fee-for-service (FFS) approaches with a gradual integration of value-based payments: category 1 includes models that use only FFS payments; category 2 includes models that use FFS payments, and later adjust for infrastructure investments, the reporting of quality data, and performance on quality and cost metrics [9]; and category 3 includes models that use FFS payments plus value-based support for achieving quality and cost outcomes. The 4th category includes models that use a population value-based payment approach that encourages providers to deliver person-centered, coordinated care and holds them accountable for the overall cost of care [9].

The sustainability of team-based care under these APMs depends on the ability and willingness of providers to tolerate some level of risk. For example, under the Comprehensive Primary Care Plus model, a category 4 model known as CPC+ [10], providers are eligible to receive a 5% incentive payment, a care management fee per member per month, and a payment under the Medicare Physician Fee Schedule paid as a lump sum once per quarter. A provider may use this income to sustain teams while holding down costs. However, these category 4 payment models have a higher financial risk and require more work for providers because they require a change in how care is delivered. For example, while payments under CPC+ will be greater than the amount practices might normally be paid, the program requires practices to address new aspects of care, including access and continuity of care, care management, comprehensive and coordinated care, engagement of patients and family caregivers, the planning of care, and population health [10].

Generally, payment models such as those in APM category 4 incentivize comprehensive care management, infrastructure support, and robust team-based care. Because of the financial support for care management and infrastructure development, providers may be better equipped to sustain team-based care over the long term.

An acute care hospital system receiving payments under an APM in category 3 or 4 will likely benefit if they successfully integrate high-functioning care teams, partner with other providers such as skilled nursing facilities, and make investments in infrastructure and staff, such as hiring data analysts, care navigators, case managers, and community workers to more effectively and efficiently coordinate and deliver care. In this case, the hospital must decide how to fairly pay team members and the skilled nursing facility under a partnership agreement.

Opportunities and Challenges of Alternative Payment Models for Team-Based Care

Each category of payment model offers both opportunities and challenges to team-based care. The most prominent challenges are those related to the costs of implementing a new team-based model of care; how to best configure, appoint, and deploy team members; and how to pay team members for their work.

The Cost of Team-Based Care and Team Members

The cost of implementing and maintaining team-based care varies widely depending on the team composition, the processes used to deliver care, and the care setting. Also, the cost depends on the type of team formed. On one hand, some teams such as those engaged in rapid response may include a standard number of team members with specific training and skills. The fixed cost of such teams might be predictable because they are comprised of standard members who are in an organization's existing pool of employees. On the other hand, implementing a clinical team in a primary care practice might require hiring new members to fill specific or new roles, or re-assigning existing members to fill different roles.

The costs associated with team-based care include both direct and indirect costs. Direct costs—those associated with the direct care of patients—are largely a function of labor. Teams are comprised of diverse types of clinicians, including physicians, advanced practice providers (APPs), registered nurses (RNs), pharmacists, and others. The exact combination of clinicians depends on provider needs, the patient population being served, local resources, and the cultural fit of team members [1]. For example, a primary care team managing care for a population of patients with diabetes might include a "teamlet" of a physician or APP and an unlicensed assistant surrounded by a larger support team comprised of an RN, social worker, pharmacist, or some other combination of providers [11]. Therefore, the cost of their salaries and benefits will vary depending on the

time each spends delivering care and the processes used to deliver and coordinate care. Some team members may be less expensive than others, however in some cases a less expensive clinician, when allowed to practice to his or her full scope of practice, may bring a level of expertise needed to deliver quality care that is similar to, or in some cases better than, a more expensive clinician, all other things considered [12]. Team efficiencies are gained when team members are combined in such a way that resources are redistributed across team members possessing the requisite expertise needed to achieve quality outcomes for a given patient population.

Providers should also consider indirect costs. For example, the costs of team recruitment, training, management, and changes that may be needed in physical spaces or information technologies can impact the overall cost of implementing team-based care. Disruptions in workflow may also occur, along with perceived power imbalances in the team structure. Because of the new payment models, providers should assess the opportunity costs of not implementing team-based care or implementing other alternatives. While difficult to measure, these costs must be considered, along with the direct and indirect costs of the team and its support.

How Providers/Teams Will Be Paid Under New Payment Models

Provider payments vary under different types of payment models. For example, CMS's Bundled Payments for Care Improvement (BPCI) initiative [13], a type of category 3 model, consolidates payments across care settings for multiple services provided during an episode of care, and pays teams in 2 ways: providers (eg, acute care hospitals, post-acute providers, and other providers) are retrospectively paid under a FFS arrangement that is later reconciled against performance indicators; or providers are prospectively paid a bundled payment encompassing all services used across settings for episodes of care [13]. All types of APMs use one or both approaches to pay providers. The key is for providers to understand the model under which they are paid, and to, in turn, pay team members in a fair and equitable manner according to the roles they fill.

Strategies

There are various reports cited in this commentary that offer guidance, principles, and strategies for building effective teams [1, 3]. Providers should strive to ensure that the core principles of team-based care are cultivated and encouraged. Principles such as developing shared goals and well-defined roles, building mutual trust, practicing effective communication, and prioritizing measurable processes and outcomes should be foundations of team-based care [1]. Building high-functioning teams requires considerable thought and planning, which should begin with an internal assessment of readiness for change, as well as the identification of barriers and facilitators [14]. Building teams

that focus on specific patient populations or subgroups is another strategy involving disease- or population-specific payment models [15]. These models target care for high-cost patient population groups such as those with chronic illnesses, for which team-based care has shown promise as a cost-effective care-delivery strategy [15].

The Future of Team-Based Care

A consortium of payers, including public and private entities, employers, providers, consumer groups, and other stakeholders has committed to creating "a better, smarter, and healthier US health care system [16, 17]." Their vision is to improve care by shifting health care payments from FFS-type models that reward providers regardless of cost or quality to APMs in which providers have responsibility and accountability for achieving quality and cost metrics. Payers seem poised to continue down the path away from FFS payment and toward category 3 and 4 APMs, which suggests that opportunities and incentives for team-based care may continue [16, 18]. Team-based care will evolve in the future, as providers create, implement, and "share the care [19]." Concerted and continued efforts to educate, train, and reward providers in team-based care delivery will improve care for patients, foster greater collaboration among providers and teams, align care delivery models with payment models, and improve the performance of our health care system overall. **NCMJ**

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