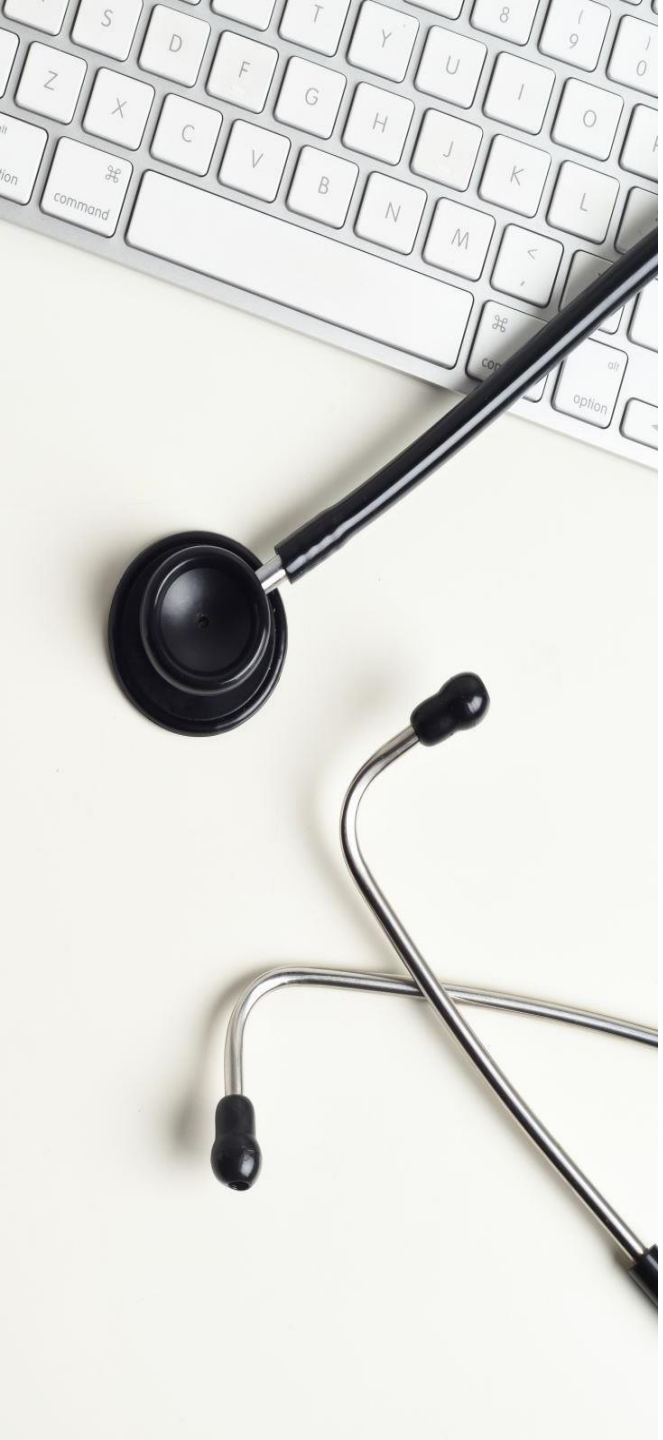
The healthcare ecosystem in the USA

1. Healthcare providers
2. Health insurance providers, also known as policy makers
3. Government organization: (FDA), the Centers for Medicare and Medicaid Services (CMS), and the National Institutes of Health (NIH)
4. Businesses that create and produce pharmaceuticals and medical equipment
5. Patients and consumers
6. Nonprofit organizations



AIM

The goal of the study is to comprehend “value-based healthcare system” and to evaluate the effect of its implementation at the global platform.

RESEARCH QUESTION

- What is the need for Value Based healthcare system?

STUDY DESIGN

- Secondary research (Descriptive study and Desk Analysis)

NEED FOR VALUE BASED HEALTHCARE

1. Value-based healthcare places the **patient at the center** of the delivery of healthcare.
2. Value-based healthcare encourages the provision of **high-quality care, leading to quality improvement**.
3. Cost management, encourages a culture of continual learning and innovation in the industry
4. Eliminating Waste
5. Population Health Management: Focuses on **enhancing the health of entire population**
6. Accountability and Transparency: Value-based healthcare **encourages honesty and openness among organizations and healthcare providers.**

IMPLEMENTATION OF VBHS MODEL ON GLOBAL SCALE

- Governments and politicians must set up regulations that reward healthcare professionals for putting value before quantity. Encouraging Healthcare profession by incentive-based system
- Cultural and contextual adaptation: Value-based healthcare ideas and tactics must be modified to match specific local conditions, taking into account things like health inequalities, socioeconomic circumstances, and cultural norms.
- Health Information Systems: Effective health information systems that can collect and analyze data on patient outcomes, costs, and quality are essential for implementing value-based healthcare. Infrastructure, interoperability, and data governance investments are necessary for the development or improvement of health information systems on a worldwide scale
- Value-based healthcare can be implemented globally with the help of international collaboration and advocacy, including work with the World Health Organization (WHO)

THE EFFECT OF VBS ON EMPLOYEE MOTIVATION AS WELL AS EFFICIENCY

1.Clarity of Purpose and Alignment: Value-based healthcare gives healthcare workers a strong sense of direction and purpose.

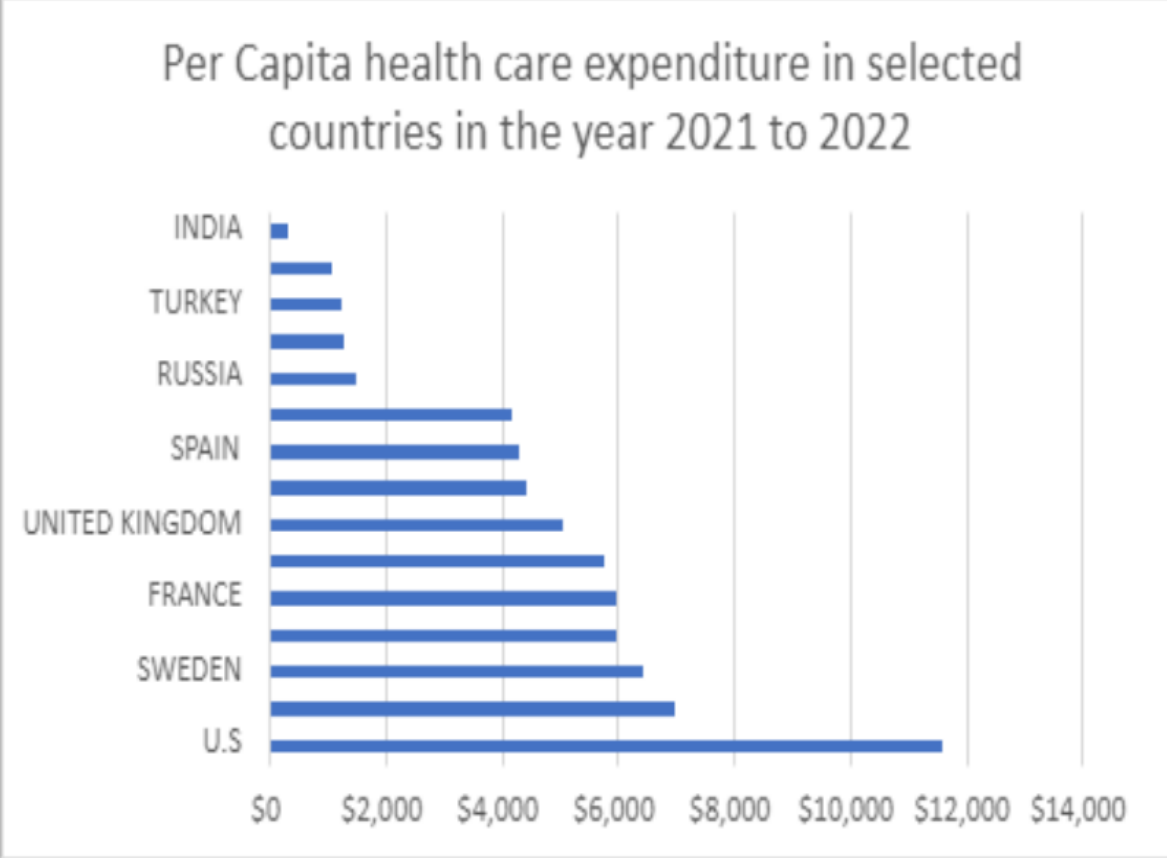
2.Patient-Centered Focus: Value-based healthcare prioritizes the needs of the patient, which may increase staff morale.

3.Value-based healthcare frequently involves performance-based incentives based on outcomes, quality indicators, and cost effectiveness. These rewards can inspire workers to perform better, produce better results, and deliver care more effectively

4.Collaboration and teamwork are promoted by value-based healthcare among healthcare workers. It encourages the use of interprofessional care teams, coordinated care, and shared decision-making.

5.Value-based healthcare encourages an environment that is conducive to ongoing learning and growth.

6.Improved Work-Life Balance: Value-based healthcare frequently places a strong emphasis on preventative care, population health management, and care coordination, which can improve employees' work-life balance



Reasons to abandon the fee-for-service approach and adopt the value-based healthcare strategy (On a global scale)

Expenditure	Services
27%	Unrequired services
7%	poor disease management prevention
10%	poor disease management
17%	Less Efficient Services
14%	Exorbitant pricing
25%	Fraud

CONCLUSION

- Global adoption of value-based healthcare has the potential for positive change in healthcare delivery systems everywhere. Value-based healthcare encourages patient centered care, improved outcomes, and cost effectiveness by moving the emphasis from volume to value. This constructive attitude has various advantages

- Patient Outcomes are Improved by ensuring that care is customized to each patient's requirements and preferences
- Value-based healthcare strives to reduce waste, cut back on unnecessary operations, and enhance care coordination. This results in increased efficiency and cost control.
- Global Collaboration and Learning: Value-based healthcare implementation fosters international cooperation and knowledge exchange across nations
- Improved Healthcare Quality: Value-based healthcare promotes a culture of innovation, learning, and continual improvement. Healthcare providers can benchmark their performance, pinpoint areas for improvement, and incorporate winning tactics from other nations by putting in place standardized outcome metrics and sharing best practices globally

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WHAT DO I DO AT FIGMD PUNE?

A Sample of Measure Specification

Quality ID #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with diabetic retinopathy seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

WITHOUT

Place of Service (POS): 12

AND

Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy: G8397

NUMERATOR:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Definitions:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

NUMERATOR NOTE: *Denominator Exception(s) are determined on the date of the denominator eligible encounter.*

Numerator Options:

Performance Met:	Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care **(5010F)**

OR

Denominator Exception:	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes **(5010F *with* 1P)**

OR

Denominator Exception:	Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes **(5010F *with* 2P)**

OR

Performance Not Met:	Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing thediabetes care, reason not otherwise specified **(5010F *with* 8P)**

RATIONALE:

Diabetic retinopathy is a prevalent complication of diabetes, estimated to affect 28.5% of diabetic patients in the US (Zhang et al., 2010). Diabetic Retinopathy is a key indicator of systemic complications of diabetes (Zhang, 2010). Coordination of care between the eye care specialist and the physician managing a patient's ongoing diabetes care is essential in stemming the progression of vision loss. Communication from the eye care specialist to a primary care physician facilitates the exchange of information about the severity and progression of a patient's diabetic retinopathy, adherence to recommended ocular care, need for follow-up visits, and treatment plans (Storey et al. , 2016). Data from the Diabetes Control and Complications Trial showed that diabetic treatment and maintenance of glucose control delays the onset and slows the progression of diabetic retinopathy (Aiello & DCCT/EDIC Research Group, 2014).

CLINICAL RECOMMENDATION STATEMENTS:

The ophthalmologist should refer patients with diabetes to a primary care physician for appropriate management of their systemic condition and should communicate examination results to the physician managing the patient's ongoing diabetes care. An Eye MD Examination Report Form is available from the American Academy of Ophthalmology (Academy).

Because patients with diabetes may be under the care of multiple practitioners, effective communication and care coordination is necessary to optimize care.

One of the patient outcome criteria is optimal control of blood glucose, blood pressure, and other risk factors through close communication with the patient's primary care physician on the status of the diabetic retinopathy and the need for optimal metabolic control.

American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp

- Role of a Clinical Research Analyst

1.Creation of foundational documents (artifacts)- data dictionaries, pseudo codes, web content creation (web tool questionnaire for a measure, dependency logic for the questionnaire), crosswalks.
2. Client liaison between clinical experts (Registry) and data mapping teams for effective extraction of data.
3. Internal consultation on clinical/ specialty-related matters. At times, gets involved in calls with practice to understand how data is documented for mapping refinement.

THANK YOU