Value-Based Payments for Podiatric Physicians

We need evidence to show how our medical specialty helps patients walk more.

BY JON A. HULTMAN, DPM, MBA

The first "National Pay for Performance Summit" was held at the Century Plaza Hotel in Los Angeles on February 7, 2006. I was honored to be selected to speak at that Summit on the topic "Achieving Collaboration Amongst Independent Physicians, on a Common Database, Employing an EHR." At that time, I felt doctors who were seeking to demonstrate better outcomes had an opportunity to prepare ahead of time for quality-based payment methods through collaboration on common databases. They would share clinical guidelines along with results so that the "best" protocols could be developed and shared by all participants—ones that had proven effective in improving treatment outcomes.

The challenge was that this process required a significant amount of physician time. Also, technology costs were significantly higher than today, and there would be no accompanying higher reimbursement awarded for the expenditure of effort or money required to develop these guidelines. We knew that a policy of higher pay for better performance would eventually be enacted, but we did not know the form that pay-for-performance would take—or specifically, which DPM quality measures, if any, would be valued by payers.

On March 8, 2017, the "Twelfth National Value-Based Payment and Pay for Performance Summit" was held at the Grand Hyatt, San Francisco. Notice, that in 2017, the phrase "Value-Based Payment" had been added to the 2006 program title "National Pay for Performance Summit." This gives clear indication of the direction that the pay for performance movement has taken.

While much discussion regarding "payment for performance" has taken place since that first Summit in 2006, those specialists who have been delivering greater quality have reaped little financial benefit. Today, with the advent of accountable care organizations, medical homes, population health, and value-based payment measurers such as PQRS, MIPS, and MACRA, the best that most independent specialists will be able to do is avoid penalties—with little chance of receiving the higher bonus payments that are purportedly being made available.

Most efforts to improve quality or lower costs have had little impact on either front; however, I believe that an opportunity still exists for specialties—especially ours—to document their far greater value to the healthcare system than current value-based payments have given them credit for. Authors of an article that appeared in the March 31, 2017 *Journal of the American Medical Association* entitled, "U.S. Spending on Personal Health Care and Public Health, 1996-2013," listed 155 medical conditions in order of the money spent on each of these "conditions." At the top of this list of conditions over this seventeen-year timeframe were the aggregated categories of: cardiovascular disease, diabetes, other non-communicable diseases (such as hypertension, obesity, and tobacco cessation), mental disorders, and musculoskeletal disorders. Following this time period (2013-2017), the category "diabetes" has accounted for the majority of U.S. healthcare spending. An article in *Harvard Health Publications* on "How Walking Works" puts this cost data in the context of the numerous studies that have been done over the past decade on the benefits of walking. The authors state that "Walking improves cardiac risk factors such as

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cholesterol, blood pressure, vascular stiffness/inflammation, and mental stress, and also helps protect against dementia, peripheral artery disease, obesity, diabetes, depression, and colon cancer." Such reports offer a strong indication of the opportunity that podiatric specialists will have to make a major impact on the future overall cost of healthcare in this country.

Podiatric medicine has always been viewed as the specialty that keeps people walking, but to tap into greater value, we need evidence to prove that we are also the specialty that gets people walking more. In addition to the outcomes of pain reduction, function improvement, and keeping people walking—which our medical, biomechanical, and surgical services deliver—an important outcome that we could document to payers is that we actually utilize protocols that have been proven to educate and motivate our patients to walk more. Similar to asking patients about smoking as part of our history-taking, we should also be asking how much they walk each day and documenting any increase in their walking that results from our treatments and visits. Many patients do not go to their doctors to quit smoking, but if they do smoke, it is incumbent on their doctors to educate them as to the benefits of quitting and motivate them to quit. Similarly, many patients who go to DPMs are not seeking to walk more; however, if when they first come for treatment they are walking less than the amount typically recommended as necessary for maintenance of good health, we need to educate them regarding the benefits of walking and assist them in increasing their amount of walking throughout our treatment. It is incumbent upon us to educate and motivate them to walk more, provide treatment so that they can walk more, and document their outcomes. If we do so, we have the potential of reducing many of the costliest conditions in healthcare today. With further research and documentation (through our common database) on the effectiveness of any treatment protocols we develop, and then employ, we will be able to present a strong case for adding a value-based payment for "walking" as well as create a stronger demand for our services. **PM**

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