

## **Basic Principles: Suggestions for Restatement and Update**

Submission by Dan Myers, M.D.3/31/08 for Work Group Consideration:

### **Basic Principle #1: Promote Cost Effective Approaches**

Suggest the use of a better term than cost effectiveness such as “value-based” which should communicate the concept of unit cost per quantum of quality. This principle should preserve the concept of “cost effectiveness” within the parameters of what the group feels is value for the patients and or population served from a clinical perspective as well as that of payers (public, private, or individuals) from a financial expenditure per episode of effectiveness.

The concept of “collaborative efforts” should be retained with perhaps with more precise delineation of the type of desirable relationships between providers. (i.e. use of EMR systems, accountable organizations, carriers, networks, or delivery groups)

In the last sentence of this principle, a listing of examples of “value-based “approaches should probably be continued but with modifications of how this is stated. (Example: the use or conversion of underutilized existing facilities is desirable and laudable only to the extent that value based quality care can be delivered at such facilities. If the facilities are too expensive to maintain or update, or if they do not lend themselves to high quality care, then there would be no clinical or financial value driven reason to encourage this conversion or utilization.)

### **Basic Principle # 2: Expand Health Care Services to the Medically Underserved.**

In the first paragraph, a better definition of those groups who are underserved should be considered. This specifically should include those who are *uninsured* or *underinsured* regardless of their age, gender, ethnic group, etc. This statement must be carefully worded so as to make sure petitioners who wish to rely on the various planning methodologies and policies can construct and specifically state their access policy and approach in a way that will be consistent with this principle to assure reasonable access to all the “underserved”. In particular, the principle may need to reference a specific documentation requirement to ensure that providers provide access to all categories of patients in their service area. Should the Division have some prospective plan outline and retrospective method of ensuring that the providers actually provide the access they plan or claim?

### **Basic Principle #3: Encourage Quality Health Care Services.**

How will quality be defined and determined? Need more specificity with regard to expected quality and outcome measurements based on national standards. Evidenced based care standards may need to be referenced for any planned services. Thought should be given as to how and what quality measures will be reviewed and which staff will actually do to do this on an ongoing basis. What are the consequences for failure to

provide high quality services? Without concurrent or retrospective review of some standards how will the Division determine quality?

**Basic Principle# 4?:**

I agree with Dr. Bradley that assurance of “patient safety” should be a separate and new basic principle. Definition of safety and safety measurements will be necessary. What are the consequences for a provider or facility that does not provide patient safety and how would this be determined? If there are no consequences, the how does one prospectively determine the ability to provide patient safety?