Now That ACOs Are Engaged, What About Those Patients?

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Coverage from the fall 2015 meeting of the ACO and Emerging Healthcare Delivery Coalition on October 15-16, 2015, at the Innisbrook Resort in Palm Harbor, Florida.

Every physician wants good patient outcomes. But being graded on them? That's another matter.

Anthony Slonim, MD, DrPH, president and CEO of Renown Health of Nevada, shared a tale of some doctors who complained about being penalized when women in their practice failed to show up for mammograms and later ended up with breast cancer.

To this, Slonim responded, "You have mechanisms to find them when they don't pay their bill." Putting some "tension in the conversation," as the longtime healthcare administrator describes it, is just one thing that needs to happen, as many doctors who have avoided alternate payment models will face them in 2016.

After years of discussion, pilot programs, and early efforts through accountable care organizations (ACOs), value-based care is poised to pick up steam. CMS has set aggressive goals for 30% of all Medicare payments to be based on alternate payment models by next year. Coupled with the implementation of Medicare Access and CHIP Reauthorization Act of 2015, which rewards those who move toward alternate models, it's clear that fee-for-service is on its way out.

The fall meeting of the ACO and Emerging Healthcare Coalition, held at the Innisbrook Resort in Palm Harbor, Florida, October 15-16, 2015, spent time on these details, but far more on the essential tool needed to thrive in a valued-based world: patient engagement.

With compensation increasingly tied to outcomes, in years to come a physician's livelihood could boil down to his skill—or system—for getting patients to take medications, follow instructions, show up for appointments, eat properly, or exercise. "Patient engagement is the next blockbuster drug," said Nicole Bradberry of Continuum Health Alliance during one of the panel discussions. It requires a mindset that doesn't give up on patients, or blame them the first time they fail to do what they're told.

Over the 2 days at Innisbrook, attendees heard how healthcare is being redesigned to look more like a customer service enterprise. ACOs have to pay attention to the bottom line, which are health outcomes, said Leonard M. Fromer, MD, executive medical director, Group Practice Forum. "It's not about checking lists," he said. "It's about changing a culture."

The Patient as "Customer"

Slonim, as chair of the meeting, described how ACOs have spent several years getting up and running. That process has been daunting, but ACOs are now turning their attention to solving problems like medication management and safety. He recognized, however, that each day brings the ongoing balancing act between "the patient in front of you," and the one sitting at home who needs an intervention to prevent a stroke 6 months from now.

One key to that balance comes from what Tina Esposito of Advocate Health Care called the "information evolution." The Chicago-area health system has gradually built up its electronic medical record (EMR) in distinct phases, going from assembling the data, to understanding what they mean, to using data to predict performance, to understanding data across a broad continuum of care.

Thus, Esposito said, data allow clinicians to make better decisions in acute situations—the patient in front of them—and, by embedding solutions into the work flow, to identify risks and head off problems. Advocate Healthcare has reduced readmis-

sions for high-risk patients by 20%, thus eliminating many long-term costs. Using data to predict customer behavior is not new—healthcare just hasn't always treated the patient like a customer. But given what patients are spending on healthcare, they expect that to change.

The meeting's second day opened with keynote speaker Leah Binder, MA, MHA, president and CEO of The Leapfrog Group. She shared a story about her elderly mother's experience in a Florida hospital, which serves a community of senior citizens. Her mother was unhappy to learn the hospital had earned an "A" on Leapfrog's latest safety evaluation; Binder asked why. Well, nothing about the facility was *unsafe*, actually. But the hospital served dinner at 7 PM, and nobody in that community eats dinner that late.

So, Binder called the hospital's CEO to discuss the problem. To her surprise, he seemed unmoved. For Binder, it seemed an example of being out of touch with the region's population—the "customers." If another hospital figures this out, they'll serve dinner early.

For too long, healthcare has failed to meet patients where they are. Doctors blame patients for not making appointments or sticking with physical therapy instead of asking what's wrong. Do they have a new job and feel they can't leave work? Do they lack transportation or child care? What if they simply need a reminder?

Bradberry noted that if a salesperson complained about customers who didn't buy their products, no one would find that acceptable. Patient engagement, she said, "is so much bigger than people think about it today." Engaged patients will be more satisfied, and these are the patients who will want to stay with their ACO, she said.

As helpful as technology is, Esposito said, it's not a replacement for one-on-one conversations. "[Having an] EMR is not enough for population health, although it is a starting point," she said. Health systems must ask patients "how we can get them engaged." Kelly Conroy, executive director of the Florida division, Aledade, agreed. Population health, she said, is "so much more than the EMR." Changing behavior is a long, difficult process.

One vehicle for getting consumer input is the patient representative on ACO boards, which was discussed in a talk on meaningful patient engagement by Matthew DeCamp, MD, PhD, an assistant professor of bioethics at Johns Hopkins University. It's important that patients know that they are represented in the governance structure, he said.

"Skin in the Game"

Slonim said health systems looking for ways to get enrollees to invest in their health—to have "skin in the game"—but they often fail to appreciate how much patients are spending on high deductibles, co-payments, and other out-of-pocket costs. Depending on how these costs are structured, they may prevent patients from seeking timely care.

In her address, Binder said most people don't realize that direct payments by consumers represent the largest source of spending

About the ACO and Emerging Healthcare Coalition

As ACOs and other emerging delivery and payment models evolve and move away from traditional fee-for-service system models toward cost-effective and value-based care, the need to understand how these models will evolve is critical to building long-term strategic solutions. The mission of the ACO Coalition is to bring together a diverse group of key stakeholders, including ACO providers and leaders, payers, integrated delivery networks, retail and specialty pharmacy, academia, national quality organizations, patient advocacy, employers, and pharmaceutical manufacturers to work collaboratively to build value and improve the quality and overall outcomes of patient care. Coalition members share ideas and best practices through live meetings, and Web-based interactive sessions. Distinguishing features are the Coalition's access to leading experts and its small workshops that allow creative problem-solving. ***The spring meeting of the Coalition will be held April 28-29, 2016, in Scottsdale, Arizona.***

To learn more or join the Coalition visit: www.ajmc.com/acocoalition.

on healthcare; she agreed that as the patient share of the bill goes up, it's creating tension about how the healthcare dollar is spent.

Traditional purchasers of healthcare, such as employers, historically make choices that benefit most of their workers; the individual consumer is going to do what is best for "me." This conflict between what's best for "me" and what's best for "most" becomes more challenging when individuals bear more of the burden, she said.

As an example, Binder described how a health plan might select a medical practice because the doctors specialize in diabetes care, and the plan believes they will help save money. But an individual patient might not want to see these doctors—and won't care about the savings. "They might say, 'I don't care. I don't have diabetes.' "

During a panel discussion, Joseph Manganelli, PharmD, MPA, of Montefiore Medical Center, said getting buy-in from a patient can be as simple as explaining how each prescription drug works, so the person doesn't stop taking it. "Explain it to patients in their own language, instead of forcing your language down their throats."

Focus on Pharmacy

If poor adherence contributes to bad outcomes, then it follows that poor medication management drives up healthcare costs. Kristina Lunner, senior director of Leavitt Partners, presented results from a research project with the National Pharmaceutical Council that showed just how big this problem is: problems in pharmacy management are responsible for 31% of all adverse hospital events and $11.2 billion in costs, with this number set to reach $19 billion by 2024.

It makes sense, Lunner said, to concentrate on medication management to improve all 3 areas of the triple aim. The research, still in its first phase, shows that ACOs feel more prepared to take on the quality improvement issues—such as reducing errors—than controlling costs. Results revealed several challenges:

- ACOs feel limited in their ability to target cost-effectiveness interventions.
- Getting the care team to buy in can be an issue—not everyone wants to adhere to restrictions or pathways.
- Right now, ACOs only see a limited amount of formulary control.

There's more experience with pathways in cancer care, and experts who shared their experience with the attendees said getting buy in from oncologists can be tricky. Too often, payers put tremendous effort into developing pathways, but they are not followed on the front lines.

But there are ways to get more cooperation. That's what John Peabody, MD, PhD, FACP, president of QURE Healthcare and Doug G. Letson, MD, executive vice president for clinical affairs at Moffitt Cancer Center, reported in their overview of an effort to use clinical performance and value (CPV) vignettes to get physicians to reduce variation in cancer care. In this method, CPV cases are recorded around priority areas, and physicians are measured on critical areas such as conducting the exam, taking a history, making a diagnosis, ordering tests, and treatment. This method spots the variation within the practice, but it requires strong leadership, especially at the early stages, to change the culture within the practice.

Nowhere are the challenges of cost and patient engagement more difficult than in specialty pharmacy. The fall meeting took place in the wake of the controversy over the price hike of Daraprim to $750 a pill, and expensive drugs were becoming a staple in stump speeches for presidential candidates.

As Peabody and Letson noted, rising cancer drug costs are pushing up premiums for middle-class families, who are seeing healthcare costs take larger shares of their income. Rebecca M. Shanahan, JD, CEO of Avella Specialty Pharmacy and J. Ike Nicoll, executive president of Provider Services, discussed how the Affordable Care Act has increased coverage but also raised the stakes when cancer strikes, because high out-of-pocket costs that can affect adherence.

These days, specialty pharmacy is doing more to anticipate side effects and provide supportive care, and pharmacists are working with patients to identify patient assistance programs for the most expensive drugs. However, there still aren't good answers for what to do about patients who stop taking their medication or skip doses because of high drug costs. After the talk, panelists said ACOs could do a better job of providing coordination and ensuring more uniformity.

The More Things Change…

The days are over when employers were unwilling to raise premiums too much or change the cost-sharing formulas, or both, Binder said. "In the old days, you weren't going to try things. You weren't willing to be too bold because you wanted your employees to still like you," she said. "That's changed because of the Cadillac tax. There's much more aggressiveness from purchasers (of healthcare) than we've ever seen."

But because people spend so much for care, they pay closer attention to what they are buying—and some things haven't changed. Patients want doctors and hospitals they trust, and they value safety, she said.

"You have to take your consumers and your patients very seriously," Binder said. The concept of an ACO is not something patients understand. The concept of protecting patients from infection *is* something they get, so ACOs should be passionate about this, because patients will respond. "It's a guaranteed way to build market share. I'm amazed at how much emotion it can elicit."